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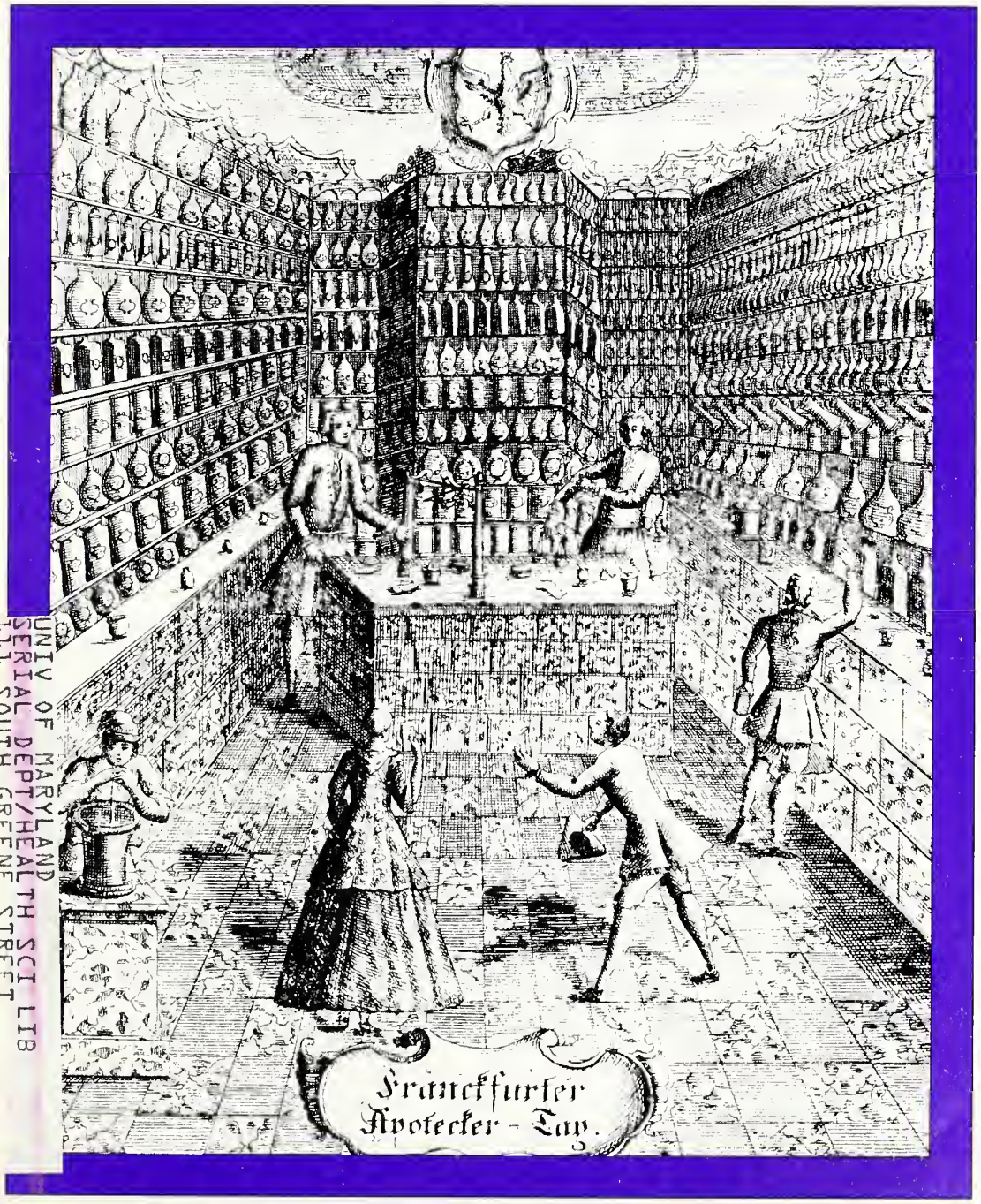
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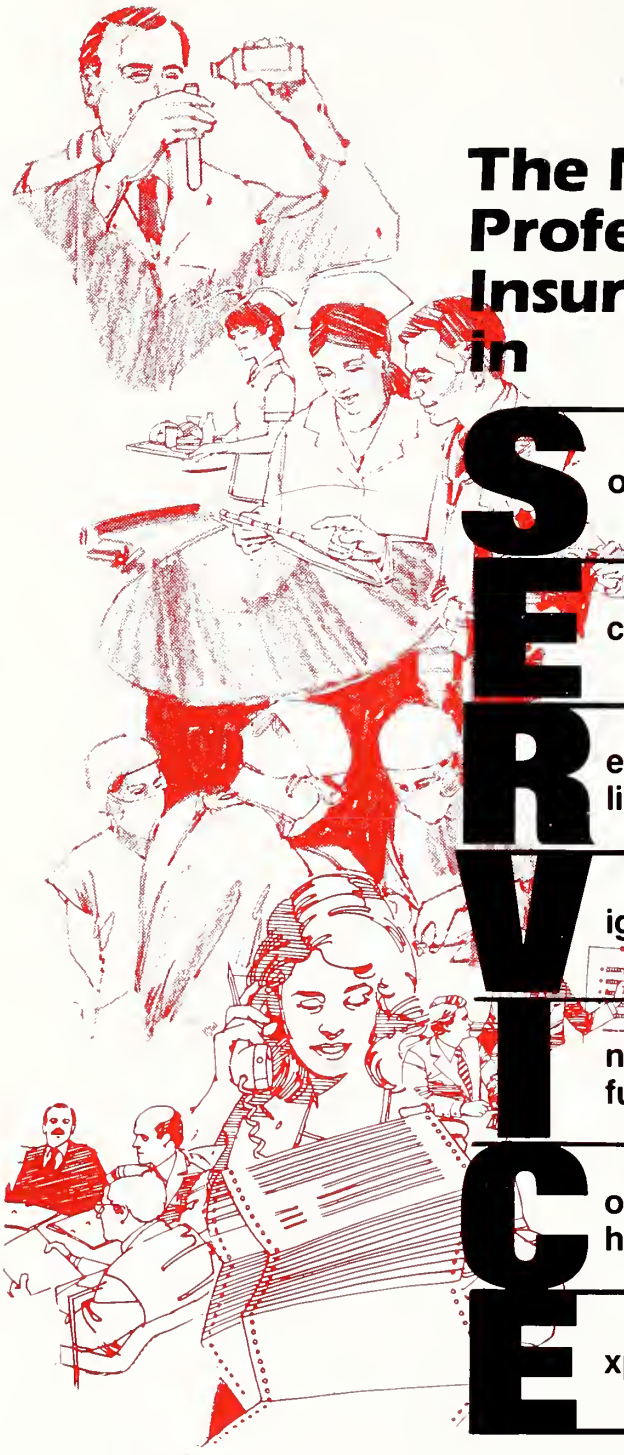
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This month's cover reproduces an etching from a book of regulations for pharmacies authored by Carl Zigrosser and published in Frankfurt, Germany in 1668. The subject is identified as: "A Seventeenth Century Apothecary Shop (German School)." This is plate 31 in the text and is reproduced from MEDICINE AND THE ARTIST (ARS MEDICA) by permission of the Philadelphia Museum of Art and Dover Publications, Inc.

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Patient Advocacy



The new year offers another opportunity for the physician to help patients maintain a healthy lifestyle.

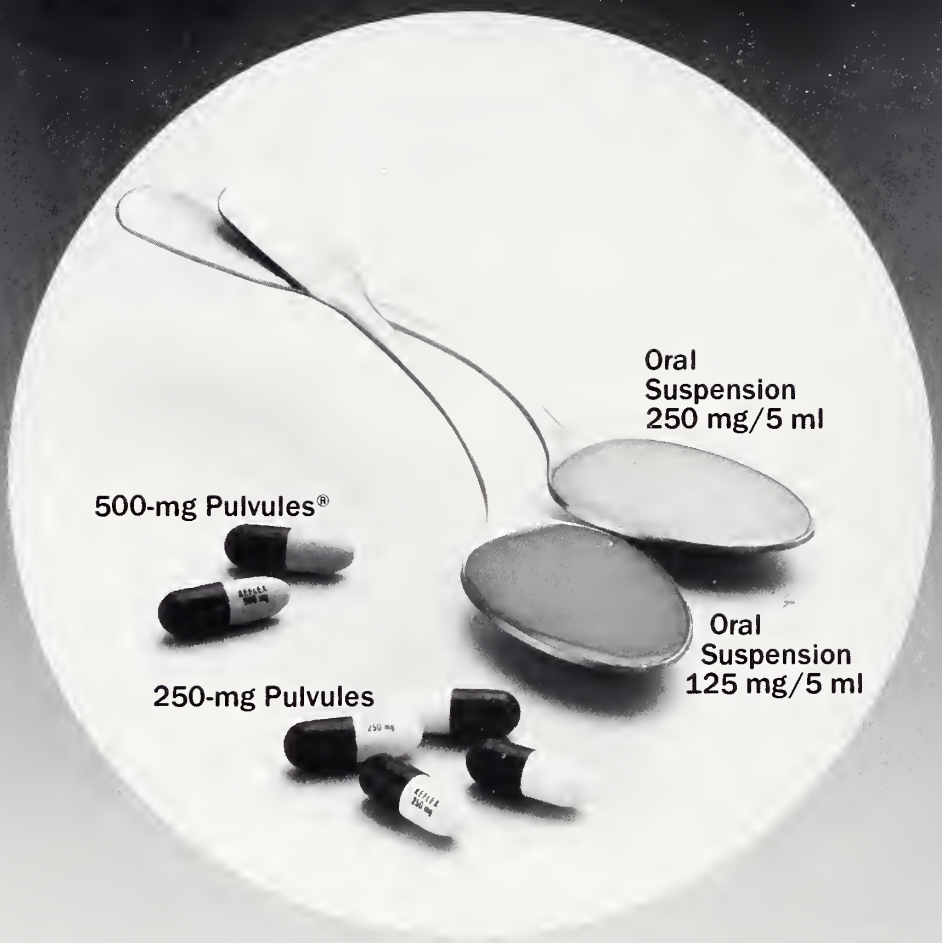
Many of our patients make New Year's resolutions to stop smoking, to lose weight, increase their exercise, and improve fitness. All of these things are good opportunities for their physician to follow-up, encourage and offer guidance. Proper prescriptions for diet, exercise and improved lifestyle may help the patient to reduce medication, improve performance and help the self-image. Physicians can encourage family exercise, sports, walking, biking, and sensible family vacation plans. These can do much, in our high-pressure, executive-type families, to bring caring, understanding attitudes to the family unit.

The physician's own family may benefit also from these same considerations. Each of them can lead to a better balance and perspective about the true worth of the individual person within the family unit and society at large. ◀

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was submitted by Clare Tempany, M.D., Department of Radiology, Loyola University Medical Center, Maywood

The first patient (Fig. 1) is a 57-year-old man who had experienced abdominal pain for the past eight months. The second patient (Fig. 2) is a 64-year-old woman with jaundice and an abdominal mass. Both patients have the same diagnosis.



Figure 1—Barium outlines a mass of the descending duodenum. The surface of the mass has a delicate, streaky appearance (between arrows).

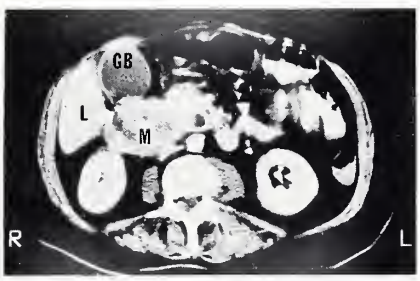


Figure 2—A large mass is inseparable from the duodenum on this CT image. L = liver; GB = gallbladder; M = mass.

Your diagnosis?
(1) Villous adenoma
(2) Lymphoma
(3) Carcinoid
(4) Ampulla of vater carcinoma

(Continued on page 45)

Quality referral care doesn't have to be inconvenient.

You know the hassles of sending patients to most referral centers. Traffic, parking and safety problems . . . these concerns can be intimidating.

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ABSTRACTS OF ACTIONS

November 1, 1985
Peoria Continental Regency Hotel
Peoria

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Foreseeability and Duty to Warn Suit

In a recent lawsuit, *Kirk v. Michael Reese Hospital, et al.*, the Circuit Court held that a hospital, physician or a pharmaceutical manufacturer does not have a duty to warn third parties of potential harm should a patient receive medication which will impair physical or mental abilities. This was taken on appeal and the Appellate Court reversed in a 2-1 decision and remanded the case for further proceedings.

The basic elements of this case are that a patient was given an injection plus oral medication. The patient subsequently ingested an alcoholic beverage. He then drove his automobile with a friend as passenger and collided with a tree. The passenger was injured and brought an action against the hospital, the physicians and the manufacturer, for failure to warn of the danger involved.

Two of the three judges on the Appellate Court concluded that doctors, hospitals, and drug manufacturers have a duty to warn patients and third parties about the propensity of any medication to impair abilities. The conclusion of the majority was that there is a duty on the part of all persons in the chain of distribution to warn. The majority opinion ignored the intervening cause in this instance, which would have been the use of alcohol.

In some opinions, this ruling has expanded the scope of foreseeability of harm and ignores the practical realities of the practice of medicine and the relationship of doctors and hospital personnel in providing treatment.

The defendants will petition for rehearing at the Appellate level and, if necessary, petition for leave to appeal to the Supreme Court.

Since this has been remanded for further proceedings, it will now go to trial, unless, of course, the Appellate Court agrees to a new hearing or it is taken to the Supreme Court.

The Appellate Court decision does establish precedent and involves significant issues for the medical profession. Legal counsel will analyze this for the purpose of determining if ISMS should file an amicus brief. The Board empowered the Executive Committee to file an amicus, pending legal counsel opinion.

Other Actions

In addressing various other issues, the Board:

- Accepted: The August 31, 1985, Financial Statements; October 15, 1985, IMPAC Collection Data Report; October 15, 1985, Dues Payment Report; and Requests for Changes in Membership Status.
- Voted to support the reelection campaign of Dr. John J. Ring for the position of AMA Trustee.
- Referred to the Governmental Affairs Council consideration of legislation for those who leave their place of employment being allowed to continue their group hospitalization insurance.
- Referred back to the Council on Medical Services for further study and report, the issue of supporting the new IDPH TB testing rules.
- Agreed to support the IDPH interim position on meeting the AIDS crisis.
- Agreed to form an Ad Hoc Committee on AIDS to review various legislative proposals and make recommendations on issues as they develop.
- Referred back to the Council on Medical Services a request that ISMS support the concept of a state cancer registry for further study and report in January, and to withhold endorsement until rules for implementation are available for study.
- Agreed to: (A) Support the concept of a need to clarify the designation of minimum requirements of state trauma centers; (B) Investigate the need for legislation to establish minimal standards to allow IDPH to designate hospitals as trauma centers in Illinois; and (C) Refer any legislation to the Governmental Affairs Council and Executive Committee to monitor or take any immediate action that may be necessary.
- Approved an Unfinished Business Report (Res. 25 A-85) entitled, "Nursing Home Residents," for the 1986 Annual Meeting.
- Referred to the Executive Committee a proposal to help guide hospital medical staffs regarding mandated limits of coverage as a condition of privilege by: (A) Sending the ISMS policy to presidents of hospital medical staffs; (B) Taking a survey to determine the local situation; and (C) Informing hospital medical staffs that third parties have no standing in mandating limits of coverage.

Nominations

The Board: (A) Ratified the nomination of Dr. Bernard C. Pecaro, Chicago, to serve as a member of the Ambulatory Surgical Treatment Center Licensing Board; and (B) Agreed to disband the IDPA HMO Contract Review Panel with commendation.

Other Matters

ISMIS/ISMIE reported that a mid-year rate increase has been deferred until the 1986-1987 policy year.

The Chairman reported that upon recommendation of ISMS, the AMA Board of Trustees awarded the Benjamin Rush Award for Citizenship and Community Service to Dr. Henrietta Herbolsheimer.

The Board reviewed the following reports from the Executive Administrator:

Contractual Nature of Medical Staff Bylaws

A recent lawsuit entitled *Lewinbuk v. Northwest Community Hospital,* was filed in the U.S. District Court for the Northern District of Illinois. This litigation arose from a proposed contract between the hospital and a Virginia corporation whereby the corporation would manage all psychiatric services at the hospital, including utilization and peer review of local physicians. This action was delayed, by agreement of the plaintiffs, to late September, at which time the physicians offered a proposed settlement, which was rejected. Following this, plaintiffs asked for an injunction, which was denied by the Federal court.

Subsequently, the plaintiffs voluntarily withdrew their suit in Federal court and refiled their action in State court. This action was taken in order to more directly address the issue of medical staff bylaws as a contract with the hospital board. Also addressed will be the issue of whether a hospital board can delegate functions controlled by the medical staff bylaws to third parties. Should this case go to judgment, it will have a very direct effect upon concerns of ISMS regarding the legal status of medical staff. This matter is being closely monitored by legal counsel.

Supreme Court Decision on Medical Studies Act

On October 3, the Supreme Court handed down a decision which held that the *results* of peer review committee action regarding a physician's staff privileges are discoverable. In this decision the Supreme Court upheld the constitutionality of the Medical Studies Act and upheld the privilege of reports or interviews arising out of proceedings of hospital committees. This is a rather narrow scope in that the Act and the peer review process continue to remain confidential but should there be an inquiry as to whether privileges have been modified due to peer review, this would be discoverable in civil litigation. This supports the legislative purpose of the Medical Studies Act: to permit candid discussion of medical care and staff privilege issues without a concern that individual comments or perceptions would be disclosed. Legal counsel has been reviewing this matter and if additional refinement is to be taken, he will apprise ISMS of this.

Suit Challenging PLI Legislation

In the lawsuit brought by Leonard Ring challenging the constitutionality of four elements of the PLI legislation, *Bernier v. Burris et al.,* trial was held the second week in October. ISMS attorneys attended the hearing of this case before Cook County Circuit Court Judge Wosik, and developed an ISMS amicus brief. The office of the Attorney General defended the state officials named in the suit.

Leonard Ring, the plaintiff attorney, called a series of witnesses to develop his argument challenging the screening panels, periodic payments, the collateral source rule, and the prohibition of punitive damage awards. On the defense side, the Attorney General also called several witnesses.

After closing arguments, Judge Wosik had no questions or comments. He instructed the parties to submit proposed findings of fact and conclusions of law, in a proposed order, by November 1, 1985.*

Editor's Note: A related story appears on page 12 of this issue.

Programs

The Board approved the development of the ISMS Physician Games in 1986, provided there is sufficier corporate support available.

Next Meeting

The next Board of Trustees meeting was set for January 25-26, 1986, at the ISMS Conference Complex. ◀

Illinois Supreme Court Agrees to Expedite Case

Circuit Court Finds Malpractice Reform Unconstitutional

Late last month, a Cook County Circuit Court judge found key elements of the Medical Malpractice Reform Act of 1985 to be unconstitutional. The Illinois Attorney General's office, which had defended the legal challenge, promptly filed a notice of appeal before the Illinois Supreme Court. The Supreme Court has agreed to hear the case on an expedited basis.

The Illinois State Medical Society reacted quickly to the Circuit Court ruling. In a statement to the state's news media, ISMS President Dr. Morgan M. Meyer said physicians and their patients "are outraged and surprised that attorneys and the court have acted unilaterally to 'undo' medical malpractice reforms the state legislature mandated this year." It is expected that ISMS will seek leave to file supporting arguments.

"The law was carefully drafted to overcome constitutional concerns raised 10 years ago by the Supreme Court," said Dr. Meyer. "It denies no patient his or her day in court."

Dr. Alfred J. Clementi, chairman of the ISMS Board of Trustees, said that physicians "naturally are disappointed and frustrated" by Judge Joseph M. Wosik's decision. "But we must not allow this temporary setback to deter us," said Dr. Clementi.

"Judge Wosik's ruling is not the final decision, and it is not one we were unprepared for," he added. "It will be the Supreme Court that will have to decide whether the State of Illinois ultimately will get medical malpractice reform."

In making his ruling, Judge Wosik said "there is no empirical data to support the claim that a medical malpractice insurance crisis exists in the State of Illinois." The judge also said "there was no need for the challenged provisions of the legislation" and that "if a need for legislation to make medical malpractice insurance more available and affordable did exist . . . the challenged provisions were not necessary to accomplish that purpose."

Specifically, Judge Wosik declared unconstitutional the sections of the law pertaining to pre-trial screening panels, structured verdicts, a sliding scale on attorney contingency fees, the collateral source rule, and abolition of punitive damages.

In explaining his action on pre-trial screening panels, Judge Wosik stated that they would deny malpractice victims the right of trial by jury, access to the courts, and equal protection of the law. Under the law, plaintiffs who pursue a case after a unanimous panel decision against them could be held liable for defense costs. Judge Wosik ruled that this possibility would "put a jury trial beyond reach of 98 percent of the citizens of Illinois."

Judge Wosik said in his ruling that the structured verdict provision "denies malpractice victims a right to have their damages determined by a jury, and thus constitutes a denial of trial by jury." The collateral source rule provision was deemed unconstitutional because it "arbitrarily discriminates between victims of medical malpractice and victims of all other torts," according to Judge Wosik.

The judge also ruled that abolition of punitive damages constituted "special legislation" in violation of the Constitution.

Finally, with respect to limits on attorney contingency fees, Judge Wosik said they are "the subject of regulation by the judicial, not legislative, branch of government." He ruled that the fee section of the law denies malpractice victims access to the courts, the right of freedom of contract, and the right to retain counsel of their choice.

Responding to the judge's decision, Dr. Clementi said ISMS "stands behind" its belief that the malpractice reform legislation will eventually be upheld by the Supreme Court. Dr. Clementi said the new law was drafted to stand up to constitutional challenges after careful review of earlier Supreme Court decisions in Illinois and cases in other states.

For example, in the mid 1970s, the Illinois Supreme Court disallowed pre-trial screening panels on the grounds that non-judicial members of the panel would rule on matters of law. "For that reason, ISMS included in its proposed legislation a proviso that only the judge serving on the panel can make such legal determinations," said Dr. Clementi.

Statement by ISMS in Response to Judge Wosik's Decision

Following is the text of a statement released by Illinois State Medical Society President Dr. Morgan M. Meyer to the state's news media.

Illinois physicians and their patients are outraged and surprised that attorneys and the court have acted unilaterally to "undo" medical malpractice reforms the state legislature mandated this year. The Illinois State Medical Society, on behalf of physicians and patients throughout the state, will work with Illinois officials for a speedy appeal of the case before the state's Supreme Court. The law was carefully drafted to overcome constitutional concerns raised 10 years ago by the Supreme Court. It denies no patient his or her day in court.

The General Assembly and its leadership deliberated long hours to forge public policy which would ease Illinois' current medical malpractice crisis. A Governor's Blue Ribbon Task Force investigated the malpractice crisis and found it real enough to warrant positive action.

No longer are physicians and their patients the only ones affected by growing litigation costs. Day care centers, municipalities, and service organizations are all suffering similar liability crises as huge court awards and expensive, time-consuming court procedures eat up liability insurance premium dollars.

For the court to deny that a crisis exists is to ignore the very real marketplace signals and expert assessments on both sides of the issue. And it bodes ill for businesses, cities and other organizations trying to reform the system.

The circuit court and Illinois plaintiff attorneys have demonstrated only their interest in preserving the status quo—a costly, inefficient legal system which benefits lawyers—not the injured patients it should serve.

How can we solve the crisis if the courts continually disallow legislative reform? Finding solutions is essential to the continued security of injured patients.

By resisting legislatively-mandated reform, attorneys and the court are contributing to future collapse of the medical malpractice litigation system they seek to "protect." These reforms, if allowed to work, will streamline the lengthy, expensive court process which injured patients must endure to receive compensation. They will also assure that the bulk of malpractice award dollars reaches injured patients rather than attorneys.

Illinois doctors and our patients will not give up the fight to restore balance to Illinois' civil justice system. The future cost and availability of health care are at stake.

We urge the Supreme Court to undertake a thorough review of the circuit court ruling and of the crisis which mandated the General Assembly to act. And we are confident that its members will view the crisis and its growing dimensions with a broader perspective than did the circuit court.

The ISMS chairman pointed to screening panels in other states which have undergone challenges based upon the denial of due process rights. To avoid similar charges, said Dr. Clementi, the Illinois law was structured to allow a plaintiff or defendant to take a case on to the courtroom—even in the case of a unanimous decision.

"On the issue of collateral source payments, we simply do not believe that any plaintiff has a constitutional right to be paid twice for the same injury," Dr. Clementi said. He added that the new law was an extension of existing Illinois law that already allows for a 50 percent offset to an award if reimbursement is received from medical insurance or other collateral sources.

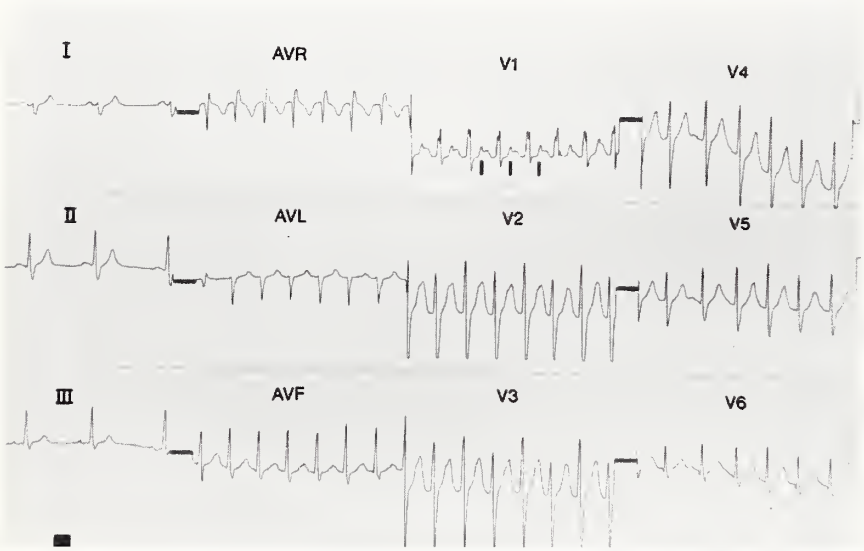
With respect to abolition of punitive damages, Dr. Clementi said previous court cases have established clear precedents in restricting punitive damages. The courts have established that no plaintiff has a vested right to punitive damages and that the legislature may restrict or deny the allowance of such damages at will, according to Dr. Clementi.

The Illinois Supreme Court also has addressed the question of "special legislation," Dr. Clementi said. "The Supreme Court previously recognized the medical malpractice crisis as ample justification for specific legislative remedies. Contrary to the arguments of plaintiff lawyers, the malpractice crisis is real. And it affects all citizens," he emphasized.

"Both the legislative and executive branches of Illinois government have recognized the crisis and acted to solve it," concluded Dr. Clementi. "With growing problems facing many segments of society, a refusal by the courts to consider serious reform may ultimately destroy the system they are trying to protect."

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was 14 years old when he was first referred for evaluation of his palpitations. The patient had experienced palpitations, associated with dyspnea and fatigue, for many years. Six months earlier, a routine physical exam had shown an irregular heart beat. An exercise ECG demonstrated frequent runs of tachycardia and poor exercise tolerance. He had had one episode of syncope one month earlier and no chest pain. The patient reported no history of rheumatic fever, but there was family history of ischemic heart disease. Physical exam showed a blood pressure of 110/70mmHg, clear lungs, and a normal cardiac test. The admitting laboratory studies included a glucose 82mg%, BUN 8mg%, sodium 141mEq/l, potassium 4.3mEq/l, chloride 104mEq/l, carbon dioxide 29mEq/l, and a normal blood count. A chest x-ray was normal. This twelve lead ECG was taken during a bout of palpitations.

Questions:

1. **The twelve lead ECG shows:**
   A. Paroxysmal sinus tachycardia.
   B. Paroxysmal atrioventricular (AV) nodal tachycardia.
   C. Paroxysmal atrial ectopic tachycardia.
   D. Multifocal atrial tachycardia.
   E. Wandering atrial pacemaker.

2. **An appropriate treatment plan for this problem could be:**
   A. Electrophysiologic study.
   B. Digoxin or quinidine.
   C. Propranolol.
   D. Verapamil.
   E. All of the above.

(Continued on page 31)

OBITUARIES

***Bonick, Thomas J.,** Chicago Heights, died December 6, 1985 at the age of 71. Dr. Bonick was a 1940 graduate of the University of Health Sciences/Chicago Medical School.

***Boykoff, Max P.,** Chicago, died November 13, 1985 at the age of 73. Dr. Boykoff was a 1938 graduate of the University of Health Sciences/Chicago Medical School.

****Braithwaite, Harold A.,** Onarga, died November 8, 1985 at the age of 92. Dr. Braithwaite was a 1923 graduate of the General Medical College, Chicago.

***Brown, F. Jack,** Henniker, New Hampshire (formerly of Decatur), died October 27, 1985 at the age of 76. Dr. Brown was a 1936 graduate of Northwestern University Medical School, Chicago.

***Ellis, Averon H.,** Evanston, died November 3, 1985 at the age of 66. Dr. Ellis was a 1943 graduate of the Johns Hopkins University School of Medicine, Baltimore, Maryland.

***Friefeld, Nathan,** South Holland, died November 23, 1985 at the age of 74. Dr. Friefeld was a 1942 graduate of the University of Health Sciences/Chicago Medical School.

***Farmans, Michael S.,** Oak Lawn, died November 18, 1985 at the age of 69. Dr. Farmans was a 1943 graduate of the University of Health Sciences/Chicago Medical School.

***Glaser, Milton R.,** Champaign, died November 4, 1985 at the age of 62. Dr. Glaser was a 1952 graduate of the University of Health Sciences/Chicago Medical School.

****Grout, John L.,** Clover, South Carolina, died December 6, 1985 at the age of 77. Dr. Grout was a 1933 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Howard, H. Sargent,** Peoria, died November 11, 1985 at the age of 74. Dr. Howard was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

****Jawor, Walter J.,** Pompano Beach, Florida (formerly of Chicago), died November 12, 1985 at the age of 76. Dr. Jawor was a 1935 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Juniper, Kerrison, Jr.,** Edinburg, died November 1, 1985 at the age of 61. Dr. Juniper was a 1949 graduate of Emory University School of Medicine, Atlanta, Georgia.

***Kopriva, James W.,** Antioch, died November 20, 1985 at the age of 67. Dr. Kopriva was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

***Lundeberg, Palmer O.,** San Diego, California, died September 2, 1985 at the age of 68. Dr. Lundeberg was a 1946 graduate of the University of Illinois College of Medicine, Chicago.

****Paschkes, Erich,** Laguna Hills, California, died November 15, 1985 at the age of 79. Dr. Paschkes was a 1931 graduate of Fak der Universitat Wien, Wien, Austria.

****Pohly, Glenn J.,** Rock Falls, died November 8, 1985 at the age of 82. Dr. Pohly was a 1930 graduate of the Northwestern University Medical School, Chicago.

Rothberg, Richard M., Chicago, died November 21, 1985 at the age of 52. Dr. Rothberg was a 1958 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

***Ruzich, Stanley E.,** Burr Ridge, died December 6, 1985 at the age of 70. Dr. Ruzich was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Sandberg, Ella R.,** Oak Forest, died October 3, 1985 at the age of 75. Dr. Sandberg was a 1935 graduate of Schlesische-Friedrich-Wilhelms-Universitat Medizinische Fakultat, Breslau, Prussia.

***Siegert, Frederick W.,** Pana, died November 12, 1985 at the age of 75. Dr. Siegert was a 1936 graduate of the Northwestern University Medical School, Chicago.

Thomson, George H., Durand, died October 30, 1985 at the age of 66. Dr. Durand was a 1949 graduate of the University of Western Ontario Faculty of Medicine, London, Ontario.

****Turner, George C.,** Chicago, died November 24, 1985 at the age of 88. Dr. Turner was a 1925 graduate of Rush Medical College, Chicago.

***Weissman, Irving,** Champaign, died November 12, 1985 at the age of 71. Dr. Weissman was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

****Woodruff, George H.,** Ft. Myers, Florida (formerly of Joliet), died October 24, 1985 at the age of 89. Dr. Woodruff was a 1920 graduate of the University of Illinois College of Medicine, Chicago.

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April 28-30, 1986
Specialty Review in Obstetrics and Gynecology
April 28-May 3, 1986
Advances in Surgery, 1986
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Ravenswood Hospital Medical Center
4550 N. Winchester
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Chairman, Department of Medicine

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Andres Gabel, M.D. Chairman
Search Committee for Medicine
Medical Staff Office 0217
Ravenswood Hospital Medical Center
4550 N. Winchester
Chicago, Illinois 60640

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education (DRE)

Erratum

In the November *IMJ* (Vol. 168:5, 320, 1985), one of the names listed in the section on "Disciplinary Orders" was "Milton Steinburg." This name was misspelled. The correct spelling is "Milton Steinberg" (lic. 036-16356 & 003-036-16356-1). The editors apologize for this error.

Disciplinary Orders

The following orders have been received by ISMS from the Medical Disciplinary Board office:

- *Joseph Abadi* (lic.# 036-042688)
  Effective November 19, 1985, Dr. Abadi was issued a conditional controlled substance license, which was placed on a probationary status, and his medical license was placed on probation.
- *Fairbank T. Chua* (lic. # 036-058983 & 003-036-058983)
  On November 20, 1985, the controlled substance and medical licenses of Dr. Chua were summarily suspended, pending a hearing at a later date.
- *Philip Kai-Ching Chung* (lic. # 036-066620)
  On November 19, 1985, Dr. Chung's medical license was revoked.
- *Robert Easton, Jr.* (lic. # 036-52215)
  On November 12, 1985, Dr. Easton's medical license was suspended pending a later hearing.
- *Frederick J. Fleury* (lic. # 036-47281)
  Effective November 27, 1985, Dr. Fleury's medical license was reprimanded.
- *Walter W. Gawron* (lic. # 036-35218)
  Effective November 19, 1985, an order was signed which placed Dr. Gawron's medical license under a 2-year probation and which also prohibited him from practicing obstetrics.
- *Rosalba Gomez* (lic. # 36-52968 & 003-036-52968)
  Under a consent agreement effective November 22, 1985, Dr. Gomez's controlled substance license was indefinitely suspended.
- *Daniel Grisham* (lic. # 036-58210)
  Effective October 16, 1985, Dr. Grisham's medical license was revoked.
- *Jaroslav Herda* (lic. # 003-036-41593-1)
  On November 20, 1985, the controlled substance license of Dr. Herda was indefinitely suspended.
- *Kirit Solanki* (lic. # 036-062910 & 003-036-062910)
  Effective November 22, 1985, Dr. Solanki's medical and controlled substance licenses remain in surrendered status and the physician indicated he does not intend to practice medicine in Illinois.
- *Eugene Tapia* (lic. # 036-035954 & 003-036-035954-1)
  On November 19, 1985, Dr. Tapia's medical and controlled substance licenses were revoked.
- *Mira Tomasevic* (lic. # 036-061721 & 003-036-061721-1)
  Effective November 19, 1985, the medical license of Dr. Tomasevic was indefinitely suspended for at least 2 years, and her controlled substance license was revoked for not less than 5 years.
- *Alejandro Villegas, Jr.* (lic. # 036-047136)
  Effective November 27, 1985, Dr. Villegas' medical license was removed from suspended to probationary status, subject to certain conditions.
- *Patricia Von Behren* (lic. # 036-54414 & 003-036-54414)
  Effective November 24, 1985, Dr. Von Behren's medical license was placed under indefinite probation and her controlled substance license was indefinitely suspended for not less than five years.

(Source: Orders signed by Director of DRE)

From the Department of Public Health (IDPH)

Hospital Licensing Board—Psychiatric Services

The Hospital Licensing Board has voted to recommend that a new rule on psychiatric services be published for public comment in the *Illinois Register*. The new rule would replace the current hospital licensing regulation which permits hospitals without an approved psychiatric service to offer "short-term" psychiatric care.

The proposed rule would permit general hospitals without an approved psychiatric service to provide psychiatric care on an emergency basis to patients with a primary diagnosis of mental illness. The rule would also require that, following appropriate psychiatric consultation, adequate and acceptable provisions for the transfer of such patients be documented and arranged within 72 hours.

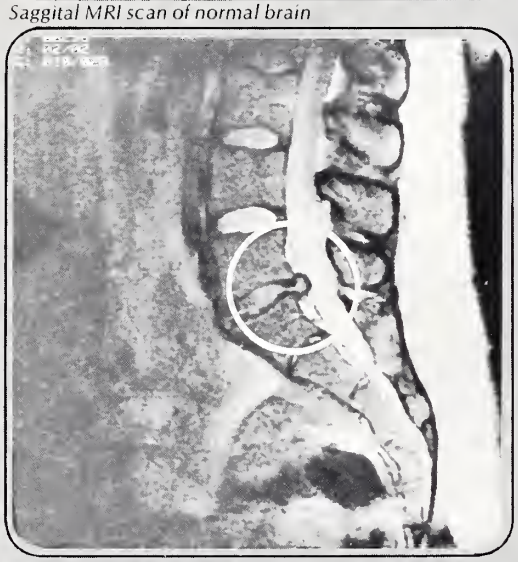
Persons interested in commenting on this proposed rule should write to the Hospital Licensing Board, IDPH, 535 West Jefferson, Springfield, IL.

(Source: December 5, 1985 meeting of Hospital Licensing Board) *(Continued on page 29)*

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Causing Adult Respiratory Distress Syndrome

Influenza A Pneumonia

By Jay A. Riseman, Donald R. Graham, M.D., Pradeep Kulkarni, M.D., Natwar Mody, M.D. and George J. Taylor, M.D./Springfield

During the 1984-85 influenza season, two previously unvaccinated adults developed adult respiratory distress syndrome with diffuse bilateral infiltrates, bibasilar rales, dyspnea and hypoxemia. The role of influenza A virus was established quickly by electron micrographic analysis of bronchial secretions. Serologic and tissue culture techniques confirmed the diagnoses. Even with prompt treatment, adult respiratory distress syndrome complicating viral pneumonia has a high mortality rate. Because immunization remains the best method of prevention, recommendations for influenza vaccine are summarized.

Type A influenza virus infection generally causes fever, cough, malaise and myalgia, but rarely causes pulmonary infiltrates.[1-3] A small minority of patients present with pulmonary edema and the adult respiratory distress syndrome (ARDS).[1-4] Due to the appearance of the chest x-ray and because ARDS may occur in patients with diabetes or underlying cardiovascular illness, ARDS is sometimes mistaken for cardiogenic pulmonary edema.[4] Recognition of the true etiology and pathogenesis of pulmonary congestion is critical for proper management. We describe two cases of viral pneumonia occurring last winter which illustrate these points and emphasize the importance of immunization in high risk patients.

Case Reports

The first patient was a 49-year-old man with insulin dependent diabetes mellitus and known multivessel coronary artery disease. He suffered from disabling angina but had refused coronary artery bypass graft surgery. Influenza A vaccination was recommended but refused.

The patient developed a fever and malaise, and was treated with amantadine 100mg. b.i.d. as well as tetracycline 500mg. q.i.d. Five days later he came to the emergency room with respiratory distress, chest pain, fever and myalgia. Examination showed tachypnea, diaphoresis, cyanosis and bibasilar rales. Cough produced blood-tinged sputum. Chest x-ray showed diffuse interstitial infiltration (Figure 1). With the patient receiving 60% oxygen by mask, arterial blood gases showed pH7.34, PaCO2 30mmHg and PaO2 46mmHg. The electrocardiogram (ECG) showed sinus tachycardia but no Q waves and no ischemic ST segment changes. The white blood cell count was 36,500/ml with a left shift. His respiratory failure worsened, requiring endotracheal intubation and mechanical ventilation. An endotracheal aspirate yielded influenza A virus, as seen on transmission electron microscopy (Figure 2), and later confirmed on tissue culture and serologically as influenza A/Philippines H3N2.

The patient's condition deteriorated rapidly. Despite intravenous furosemide, urine output remained scant and arterial blood pressure fell. Repeat ECG showed new ST segment elevation in inferior leads. A Swan-Ganz catheter was inserted and showed pulmonary artery diastolic pressure of 30mmHg. The patient died, with cardiogenic shock and electromechanical dissociation two hours after hospital admission.

At autopsy, diffuse pulmonary

congestion with inflammatory tracheitis consistent with acute influenzal infection was found. The size of the left ventricle was normal and without scar.

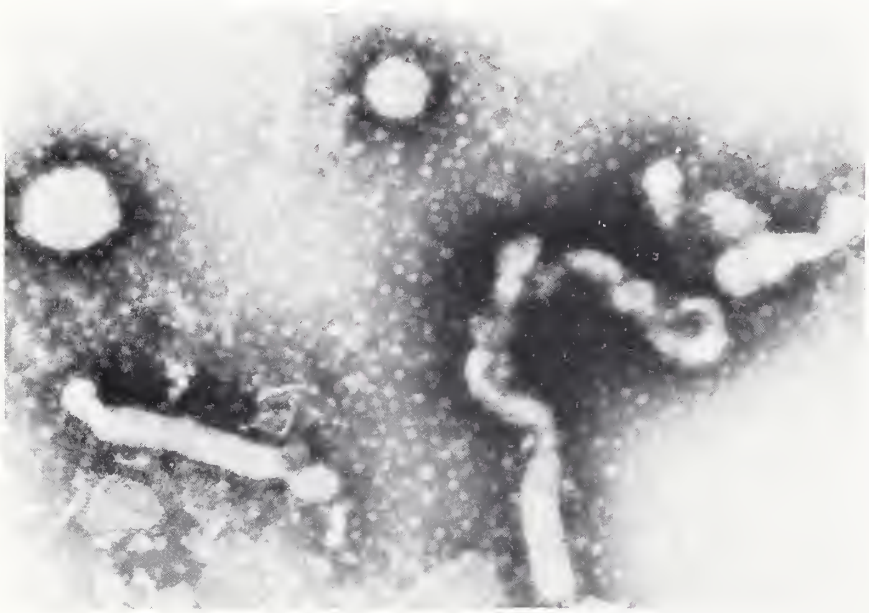
Second Case

This 30-year-old man with lifelong insulin dependent diabetes mellitus had not received influenza vaccine. Two months earlier, he had been hospitalized with chest pain, but no change in ECG. For two days before this admission he had experienced fever, weakness and nausea. Increasing respiratory distress, cough and pleuritic chest pain resulted in hospital admission. Examination showed cyanosis, bibasilar rales, tachycardia and a summation gallop. Chest x-ray showed diffuse pulmonary congestion but normal heart size. The ECG showed right axis deviation but no Q waves or ST-T wave changes. He was treated with intravenous furosemide without improvement over the next 18 hours. Because of pulmonary infiltrates and recent hospitalization for chest pain, the patient was believed to have cardiogenic pulmonary edema despite the absence of ECG abnormalities. Urgent cardiac catheterization was recommended because of worsening respiratory distress and pulmonary congestion. Angiogram showed normal coronary arteries and left ventricular function with left ventricular end-diastolic pressure of 14mmHg, excluding heart failure as a cause of pulmonary congestion. He was treated with 40% oxygen and within two days pulmonary infiltrates resolved spontaneously. Sputum cultures yielded no bacterial pathogens. Complement fixing antibody titers for influenza A virus rose from <1:8 to 1:64 over a four week period.

Figure 1
Chest x-ray on first patient showing diffuse pulmonary infiltrates.



Figure 2
Transmission electron photomicrograph from tracheal aspirate showing influenza A virus; filamentous and spherical forms are present.



Discussion

Both patients presented with pulmonary congestion and severe respiratory distress and were initially thought to have cardiogenic pulmonary edema. However, neither had a history of myocardial infarction or ECG evidence for acute MI. Both had normal heart size on chest x-ray associated with diffuse pulmonary infiltrates. This combination of pulmonary edema in the absence of cardiac findings raised the possibility of ARDS. The first patient, known to have coronary artery disease, later had myocardial infarction precipitated by ARDS and died in cardiogenic shock. The second recovered with oxygen therapy.

ARDS results from injury to the alveolar-capillary membrane with subsequent exudation of both fluid and high molecular weight contents of serum into the interstitial and alveolar spaces. ARDS has a number of potential etiologies. In young adults with no exposure to toxins and no other acute illness, viral pneumonia is a common cause. Our two patients had the typical influenza prodrome, with fever, myalgia,

malaise and cough. Both had either culture or immunological confirmation of influenza A infection.

The annual incidence of influenza is 10%-20%. Pulmonary complications were detected in 9.5% of Fry's series of 840 patients,[5] but pneumonia and ARDS were rare. The highest mortality risk with influenza occurs in adults with pulmonary and cardiovascular disease. Young patients with primary viral pneumonia generally have associated conditions: diabetes mellitus, heart disease or pregnancy.

Primary viral pneumonia with ARDS has a high mortality rate, often because of secondary pneumococcal or staphylococcal infection.[6] While amantadine is useful in prophylaxis of influenza A and therapy of nonpneumonic cases, it is of unproven value in the treatment of primary influenza A pneumonia. This was demonstrated by our first patient, who had been treated for five days with amantadine and still developed respiratory failure.

Conclusion

Immunization of susceptible patients to prevent this rare but potentially lethal complication of influenza A infection is critical. Every year the Advisory Committee on Immunization Practices recommends the vaccine strain and groups to be vaccinated. Their recommendations for 1985-86 target groups of persons over age 55, patients with diabetes, chronic heart, lung and kidney disease and health care personnel.[7] These vaccines should be administered in the fall before outbreaks occur. If influenzal infection does develop, serologic methods can confirm the diagnosis in two to four weeks. Electron microscopic techniques and tissue culture are much more rapid, but are available only in major centers. In a setting of a confirmed outbreak of influenza, antiviral chemotherapy should be given to persons presenting with typical symptoms of fever, cough, headache and myalgia. In addition, all non-vaccinated susceptible individuals, especially those at high risk for complications, should be given the vaccine. ◀

References

1. Fry, J.: "Influenza A (Asian) 1957, Clinical and Epidemiological Features in a General Practice," *Br Med J* 1: 259-61, 1958.
2. Louria, D.B., Blumenfeld, H.L., Ellis, J.T., Kilbourne, E.D., Rogers, D.E.: "Studies of Influenza in the Pandemic of 1957-1958. II Pulmonary Complications of Influenza," *J Clin Inv* 38: 213-65, 1959.
3. Glezen, W.P.: "Viral Pneumonia as a Cause and Result of Hospitalization," *J of Infect Dis* 147(4): 765-70, 1983.
4. Taylor, G.J., Brenner, W., Summer, W.R.: "Severe Viral Pneumonia in Young Adults," *Chest* 69: 7, 22-28, 1976.
5. Fry, J.: "Influenza, 1959, The Story of an Epidemic," *Br Med J* 2: 135-8, 1959.
6. Barker, W.H., Mullooly, J.P.: "Pneumonia and Influenza Deaths During Epidemics, Implications for Prevention," *Arch Int Med* 127: 85-9, 1982.
7. Immunization Practices Advisory Committee: "Prevention and Control of Influenza," *Morbid Mortal Weekly Rep* 34: 261-75, 1985.

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Non-Steroidal Anti-Inflammatory Drugs

Drug Therapy for Dysmenorrhea

By Roger P. Smith, M.D./Urbana

It has been estimated that of the 35 million women of childbearing age in the United States, 30%—50% suffer from painful menstrual periods. Ten to fifteen percent of women have sufficient discomfort to affect their ability to participate in work, school, or family life. Dysmenorrhea is the leading cause of recurrent short-term school and work absenteeism among women of childbearing age.[1] In 1945, it was estimated that 140 million work hours were lost annually,[2] and this number is certainly much greater with today's larger female work force.

For many years, this disorder presented a frustrating dichotomy between severe, incapacitating symptoms and an often normal physical examination. Only in the last decade have several lines of research come together to delineate the pathophysiology of primary dysmenorrhea; and with this new understanding, rational and effective treatment is finally becoming a reality. Today, the use of non-steroidal anti-inflammatory (NSAI) drugs has fulfilled the promise of safe and effective therapy. The clinician now faces a new problem; how to select the appropriate drug for his patient. By understanding this class of drugs, their actions, and the results of clinical trials, the selection process may be made much easier.

The idea that menstruating women are "unclean" and carry the ability to wilt flowers, spoil preserves, or cause bread to fall,[3,4] is widespread throughout many cultures and locations. These beliefs appeared to be given scientific basis by the finding of a "menstrual toxin" present in menstruating women.[3] In 1957, Pickles reported that acetone and ether extracts of menstrual fluid contained a powerful "plain-muscle stimulant."[5] These findings were confirmed and expanded and the source of the stimulant was identified as the sloughing endometrium.[6-9]

By 1963, these stimulants had been identified as prostaglandins.[10-12] In 1965, Pickles reported elevated levels of prostaglandin F_{2a} (PGF_{2a}) in the menstrual fluid of dysmenorrheic women.[13] The probable role of prostaglandin F_{2a} in causing dysmenorrhea was established when studies duplicated dysmenorrhea-like pain and uterine activity after intravenous injection.[14] The connection was now complete between excess uterine prostaglandin F_{2a}, increased uterine activity, and the pain of dysmenorrhea.

In the menstruating uterus, the production of PGF_{2a} begins when phospholipase A_2 converts the phospholipids of dead cell membranes into arachidonic acid. (Figure 1) Arachidonic acid may be metabolized by at least two enzymes: lipoxygenase, which begins the production of leukotrienes, and cyclo-oxygenase, which leads to the production of the unstable cyclic endoperoxides (PGG_2 and PGH_2). Leukotrienes are potent vaso-active compounds and bronchoconstrictors. They are also thought to be very important in mediating inflammatory and allergic processes. The cyclic endoperoxides formed by the action of cyclo-oxygenase are acted upon by tissue specific enzymes to form prostacyclin (PGI_2), thromboxanes, and the prostaglandins PGD_2, PGE_2 and PGF_{2a}. In the endometrium, it appears that the major products are PGE_2 and PGF_{2a}. Prostaglandin E_2 is a potent platelet disaggregator and vasodilator, while PGF_{2a} is a mediator/potentiator of pain sensation and a strong stimulator of smooth muscle contraction.

It would seem apparent that if prostaglandin synthesis can be reduced, menstrual pain can be prevented or lessened. In 1967, it

was again Pickles who showed that prostaglandin levels were lower during anovulatory cycles,[15] a finding that prompted the use of oral contraceptives to suppress ovulation and relieve menstrual pain. While this approach is usually successful, not all patients can or want to take oral contraceptives.

A more direct method of altering the physiologic sequence leading to discomfort has come in the form of Non-Steroidal Anti-Inflammatory (NSAI) drug therapy. These drugs inhibit the production and/or the action of prostaglandins, are generally well tolerated, and need only be taken at the time of menstruation. Oral contraceptives act to reduce the substrate available to the reaction, while NSAI drugs act to block the pathway at two later enzymatic steps.

Classification of Agents

There are two broad classes of NSAI compounds, each with subgroups. (Figure 2) Drugs of the enolic acid type appear to be primarily Type II inhibitors of prostaglandin synthesis. These agents act through the inhibition of the isomerase/reductase step in the formation of PGE_2 and PGF_{2a}. The most frequently used agents in the enolic acid groups are phenylbutazone and piroxicam. While phenylbutazone is an effective short term analgesic for musculoskeletal pain (through anti-prostaglandin activity), its relative toxicity has limited its use. Piroxicam has a long half-life (50 hours) which allows once-a-day dosage. Its action as an anti-inflammatory drug is well established, but its use for the indication of dysmenorrhea or as an analgesic has not been fully evaluated.

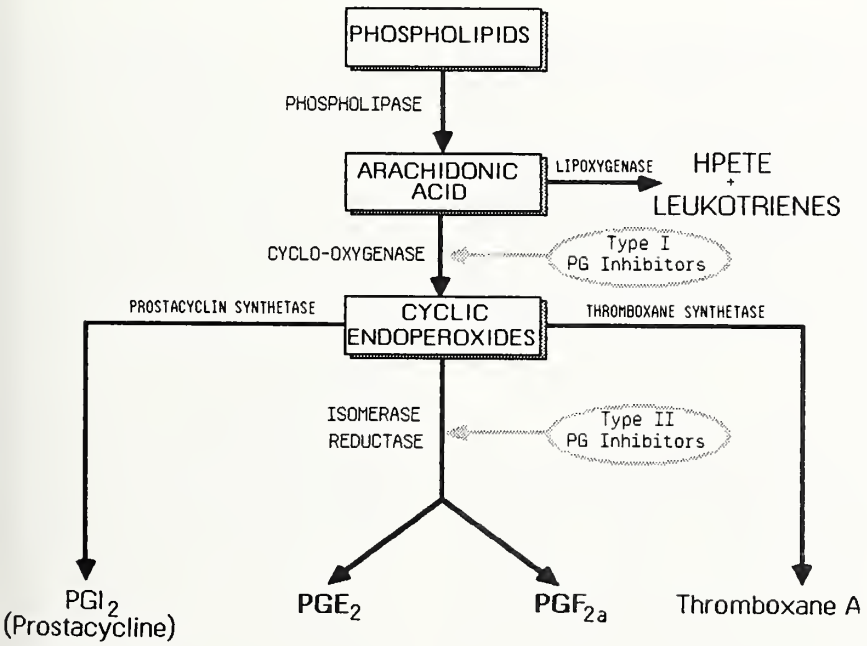
It is the carboxylates that most physicians are familiar with and utilize on a day-to-day basis for pain relief and dysmenorrhea. Within this major group there are four families of compounds which have individual characteristics. The salicylic acids and esters appear to inhibit cyclo-oxygenase by the donation of their acetyl group to the enzyme. The most recognized agent in this group, aspirin, has a very low potency for reducing prostaglandin synthesis and, hence, has had little clinical utility in the treatment of moderate or severe dysmenorrhea.

Increased potency is seen in the acetic acid groups. While sulindac must undergo reduction to a sulfide form before becoming active, most of the drugs in this group are effective as anti-inflammatory and analgesic agents. In several studies, indomethacin has shown usefulness in treating dysmenorrhea, but a moderate incidence of side effects has also limited the use of this and most other drugs in this class for treating dysmenorrhea. The most commonly used drugs for dysmenorrhea come from two classes: arylalkanoic acids (propionic acid derivatives) and anthranilic acids (fenamates).

Of the propionic acid derivatives currently available, only ibuprofen and naproxen are approved and commonly used for this indication. Other drugs of this class (benoxaprofen, ketoprofen, fenoprofen) have been used for pain relief or arthritis therapy, but are not approved for dysmenorrhea. Ibuprofen was the first drug of this class to be studied in dysmenorrhea[16] and has shown effectiveness in subsequent subjective studies.[17-19] The most studied (at least most widely reported) drug of this class is naproxen. The subjective studies of naproxen and naproxen sodium have shown good pain relief in dysmenorrhea,[20-22] even in the presence of intrauterine devices.[23,24]

The fenamates are potent prostaglandin synthetase inhibitors, but, in addition, have been shown to antagonize the actions of already formed prostaglandins.[25-30] Some of the first non-steroidal anti-inflammatory drug studies in dysmenorrhea used these agents,[31] and further studies have proven them to be very effective in reducing the subjective discomfort of dysmenorrhea.[32-36] In this country, mefenamic acid is approved for dysmenorrhea, and clinical studies supporting the use of meclofenamate are

Figure 1



Biosynthesis Of Prostaglandins

well under way. The dual action of synthesis inhibition and direct antagonism should give these agents an edge in efficacy. New *in vitro* studies have shown meclofenamate to inhibit the activity of 5-lipoxygenase, while members of the propionic acid group have little or no inhibitory ability.[37-39] The clinical significance of being able to inhibit the production of the extremely potent leukotrienes is yet to be fully explored.

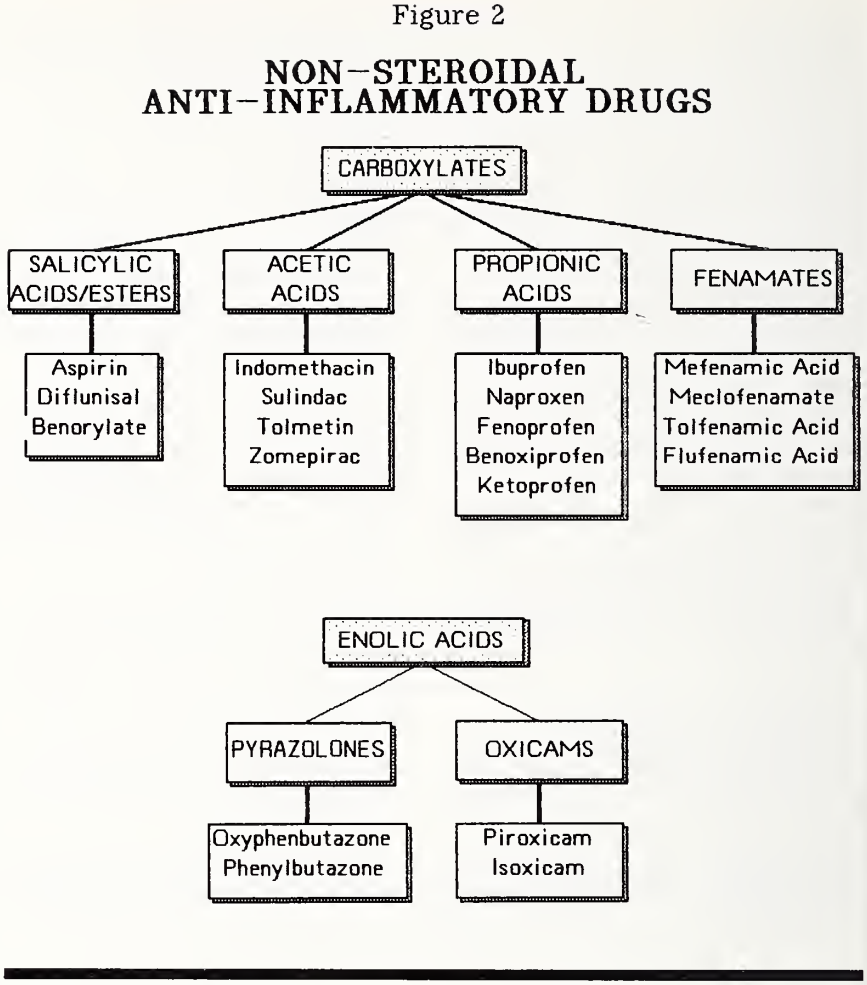
Clinical Application

Differences in the experimental design of subjective studies make comparison of efficacy rates difficult at best. Several review articles have been published which attempt to make comparisons among the most commonly studied compounds—the fenamates (tolfenamic and mefenamic acids), the propionic acid derivatives (ibuprofen, naproxen and naproxen sodium), and indomethacin.

A 1970 review by Jacobson[40] reported successful pain relief in 64%-100% of patients from 16 studies of NSAI agents in dysmenorrhea. Unfortunately, many of these studies were not double-blind, and many did not report the presence or absence of side effects. A report by Dingfelder[41] evaluated 23 trials published from 1970 to 1980 and found 67%-86% pain relief. In a recent and more thorough review, Owen[42] has criticized Dingfelder for omitting 19 additional trials from the same period. Owen presents data from 51 reports and has attempted to analyze the diverse methods, designs, and outcomes. While she found an 87% "excellent" pain relief for the fenamates versus 56%, 68%, and 56% for ibuprofen, indomethacin, and naproxen, her summary has lumped two different drugs (tolfenamic and mefenamic acids) together, and incorrectly reported or interpreted at least one reference which deals only with methodology and work in progress.

In the proceedings of a recent symposium, Tolman[43] reports clinical efficacy which ranges from slight to no effect for aspirin, and up to greater than 95% response with indomethacin, flufenamic acid, mefenamic acid, and ibuprofen, based on a large series of trials from 1974 to 1983. However, response rates still varied widely from study to study. Prendergast[44] has also provided a broad review of the many therapeutic options available, but correctly avoids drawing any conclusions. Differences in study design, dependent variables, inclusion and exclusion criteria, and the very nature of subjective pain studies make this inevitable.

Figure 2



Objective Studies

During the past few years, 15 papers have been published which report drug evaluations based on intrauterine pressure measurements. If we ignore questions regarding the relative merits of the various recording techniques employed,[45] these objective studies might logically come closer to allowing drug to drug comparisons. Unfortunately, of the 15 papers know to this author, three have only republished previously reported data,[46-48] and five of those remaining report only subjective trends, with no numerical or other analysis presented.[49-53] This leaves seven papers that present numerical data for comparison.[54-60] These papers represent data obtained from a total of 68 patients on medication, with a range of 3-13 per study. Of the seven papers, two are double-blind studies[56-60] and of these only one presents data from a controlled crossover study.[60]

Efforts to compare these seven papers seem to show an improved objective response when dysmenorrhea is treated with mefenamic acid over that found for naproxen and ibuprofen.[51] This superiority is not clear-cut, and although one study[60] showed an almost 50% rate of complete loss of uterine contractile activity on mefenamic acid, differences in protocols, data analysis and procedures make any conclusions speculative at best.

Few direct comparisons of one

drug to another have been carried out.[16,17,22,32,36,62,63] While most of these have shown superiority of the active drug over placebo, and occasionally shown trends favoring one drug or another, no study has had sufficient statistical power to separate the efficacies of the active agents tested.

Table 1
Clinical Drug Usage*

DRUG	INITIAL DOSE	FOLLOWING DOSE
ACETIC/SALICYLIC ACIDS:		
Indomethacin	25mg	25mg t.i.d.
Tolmetin	400mg	400mg t.i.d.
Sulindac	200mg	200mg q4-6h
Diflunisal	1000mg	500mg q12h
Zomepirac	(Removed from market)	
PROPIONIC ACIDS		
Ibuprofen†	400mg	400mg q4h
Naproxen	500mg	250mg q6-8h
Naproxen Sodium†	550mg	275mg q6-8h
Benoxyprofen	(Removed from market)	
Ketoprofen	(Removed from market)	
FENAMATES		
Mefenamic Acid†	500mg	250mg q4-6h
Meclofenamate	100mg	50-100mg q6h
Flufenamic Acid	(Europe only)	
Tolfenamic Acid	(not available)	
PYRAZOLONES		
Oxyphenbutazone	100mg	100mg t.i.d.
Phenbutazone	100mg	100mg t.i.d.
OXICAMS		
Piroxicam	20mg	20mg qd
Isoxicam	(not available)	

**Consult full prescribing information before using any of these drugs.*
†FDA approved for primary dysmenorrhea

Clinical Implications

As no single agent has been found definitively superior, and given all of the options available (Table 1), how should the clinician choose an appropriate therapy when the diagnosis of primary dysmenorrhea is made? The body of evidence seems to slightly favor the use of mefenamic acid, but naproxen and ibuprofen are both sufficiently effective that the choice may be moot. Once an agent is selected it should be tried over the course of two to four cycles before success or failure should be assessed. If therapy is unsuccessful, some patients may still have favorable response to another NSAI drug. This second choice should be chosen from a different chemical class for the best chance of success. Patients should be reminded to take their medication at the onset of menstruation or symptoms, and maintain consistent medication for as long as symptoms would normally last if medication had not been taken.

The physician should always be aware of the potential for side effects with any medication. While side effects for these three medications are infrequent and generally mild, serious side effects are possible, although the short duration of use in dysmenorrhea limits these risks. If pain relief is not complete, patients should be warned not to add additional analgesics, especially NSAI's, because of possible potentiation of gastro-intestinal and other side effects. When at least partial relief of the symptoms of dysmenorrhea is not achieved, serious reappraisal of the original diagnosis of primary dysmenorrhea must be made.

Through careful evaluation of the individual patient's symptoms and physical findings, it should be possible to make the diagnosis of primary dysmenorrhea and select the most appropriate mode of therapy, be it analgesic, hormonal or NSAI, to allow a full, comfortable, and productive lifestyle. ◀

References

A complete list of references for "Drug Therapy for Dysmenorrhea" may be obtained by writing the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

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A Case Report

Complications of Tonsillopharyngitis

By Orrin Davis M.D., Allan Wolff M.D., and Charles Z. Weingarten M.D./Chicago and Evanston

Treatment of bacterial tonsillopharyngitis is focused on prevention of rheumatic fever and suppurative complications. Both of the latter conditions are rare. We present a case of a 29-year-old female who was treated for presumed streptococcal tonsillopharyngitis which developed into lateral pharyngeal space and retropharyngeal space abscesses. This was complicated by signs of peritonitis that resolved after the neck and a right pyothorax were drained. Despite this therapy, the patient became comatose and developed signs of mediastinitis, Adult Respiratory Distress Syndrome (A.R.D.S.) and Disseminated Intravascular Coagulopathy (D.I.C.). The anatomy of the neck is reviewed in order to better understand how an inflammatory process of the neck can spread to the chest and cause signs of peritonitis, pyothorax and mediastinitis.

The primary goal in management of the patient with sore throat is to distinguish viral from bacterial pharyngitis. The main impetus for antibiotic treatment is to prevent rheumatic fever and suppurative complications.[1] Treatment is also aimed at relieving symptoms and restricting dissemination. Treatable causes of bacterial tonsillopharyngitis include group A beta-hemolytic streptococcus, Neisseria gonorrhoeae, Mycoplasma pneumoniae, Corynebacterium diphtheriae, non-group A streptococcus, Haemophilus influenza, and Legionella pneumophila.[2,3]

Suppurative complications of tonsillopharyngitis are not benign. Morbidities include peritonsillar abscess, parapharyngeal abscess and carotid sheath infections.[4] Localized pharyngotonsillitis induces bacteremia.[5] Forty reports of fatal myocarditis following tonsillitis have been noted at this writing.[6] We present a case of a healthy young female who suffered severe complications following a bout of streptococcal pharyngitis.

Case Report

A 29 year old black female visited an emergency room for sore throat of two days duration. A throat culture was obtained, and she was treated with intramuscular and oral penicillin. Despite therapy, her conditioned worsened and neck swelling was noted. Dysphagia, odynophagia and increased fever occurred. Lateral neck films were obtained when she returned to the emergency room. (Figure 1) She was given intravenous antibiotics, and CAT scan of the neck confirmed the retropharyngeal abscess and demonstrated a parapharyngeal space abscess. (Figure 2) White cell count was 22,100 cells/ml with a left shift (73% segs, 20% bands). Her past medical history was insignificant. At this time she was transferred to our institution.

Physical examination upon arrival demonstrated a black female in distress with a temperature of 101°F, pulse of 144, respiratory rate of 36, muffled voice, trismus and marked facial and neck swelling. (Figure 3) Oral examination revealed enlarged, medially displaced tonsils. The oropharynx and tonsils were covered with exudate. Bilateral tender cervical adenopa-



Figure 1.
Lateral neck film demonstrating retropharyngeal abscess.

thy was noted. Initial abdominal exam was normal. Four hours later, bowel sounds were lacking, the abdomen had become diffusely tender and rigid, and rebound was noted in all quadrants. The possibility of ruptured viscus was entertained, but x-rays revealed only a small amount of fluid in the right chest. There was no subdiaphragmatic air. The white count fell to 5400.

Surgery

Drainage of the neck abscess was performed via the left neck. Nearly 50cc of purulence was found deep to the sternocleidomastoid muscle. The tissues of the deep neck were greyish-green and edematous. The operator's fingers glided easily from the left side to the right neck in the retropharyngeal plane because the abscess had opened this potential space. The abscess cavity reached the base of the skull superiorly and the thoracic inlet inferiorly. A small abscess travelled anterior to the thyroid gland. Drains were placed.

Postoperative chest x-rays revealed increased right-sided pleural fluid and widening of the mediastinum. A right chest tube was placed, and more than 600cc of purulent material were suctioned. The abdomen softened and bowel sounds returned.

Gram stains of the neck and pleural fluids revealed many gram-positive cocci in pairs and chains and gram-negative bacilli. Cefoxitin and gentamicin were administered.

During the next 24 hours, the patient's temperature rose to 105.6°F and the white cell count fell to 3900. Metabolic acidosis and ventilatory insufficiency developed. Pulmonary compliance fell and chest radiographs demonstrated a pattern of bilateral diffuse infiltrates consistent with the Adult Respiratory Distress Syndrome (A.R.D.S.). Mechanical ventilation with positive end expiratory pressure was instituted. The possibility of undrained pus in the right neck was considered, and in view of the patient's deteriorating condition, the right neck was explored, but no loculation was found.

Cultures of the neck and chest drainage grew penicillin-sensitive

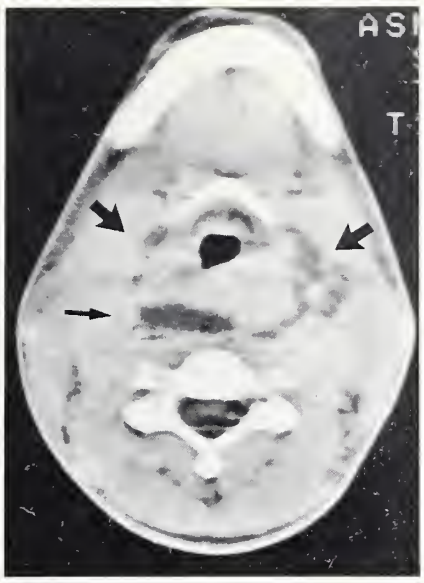


Figure 2.
C.A.T. scan of the neck at the level of the hyoid bone reveals air and pus posterior to the pharynx (thin arrow) in the retropharyngeal space, and lateral to the pharynx in the parapharyngeal space (large arrows).

group C beta-hemolytic Streptococcus and Bacteroides melaninogenicus. Spiking fevers and tachycardia persisted despite high dose penicillin therapy. The hemoglobin, platelet, calcium and phosphorous levels fell. She became unresponsive and totally ventilator dependent. Localizing neurologic signs were absent. EEG, lumbar puncture, and CAT scan of the brain, neck, chest and abdomen were not diagnostic.

On the seventh hospital day, the platelet count fell to 17,000/mm, the fibrin split products rose to 128, and the bleeding time was greater than 20 minutes. Heparin reversed these trends.

Tracheostomy was performed after eight days of nasotracheal intubation. The left lobe infiltrate progressed, and on the 14th hospital day, open lung biopsy and pericardotomy were performed. A left chest tube was placed. A total of 300ml of sterile serosanguinous pleural fluid and 150cc of similar pericardial fluid were removed.



Figure 3.
Profile of patient on admission.

During the next week, calcium, phosphate, and white cell counts normalized. The neck and facial swelling resolved. The chest x-ray cleared and the ventilator and mental status improved. Assisted ventilation and positive end expiratory pressure were discontinued on the 30th hospital day. The tracheostomy was closed, and patient was discharged neurologically intact, 38 days after admission. (Figure 4)

In summary, this young woman developed a deep neck abscess following streptococcal tonsillopharyngitis. Pus spread via the neck into the mediastinum and chest and caused diaphragmatic irritation, creating a picture of peritonitis. The patient became septic, developed A.R.D.S., hypocalcemia, hypophosphatemia and D.I.C. She was comatose and ventilatory dependent for over a week. The patient improved following drainage of both necks and chests, pericardotomy and prolonged high-dose antibiotics. Tonsillectomy was advised.



Figure 4.
Profile of patient on discharge, 38 days later.

Discussion

Infections of the deep neck are potentially fatal. Communication between the neck and the chest permit purulence to travel inferiorly, where catastrophe may occur. The contents of the neck (the muscles, nerves, vessels and viscera) are

encased and separated by thick layers of connective tissue called fascial planes. Potential spaces exist between these fascial planes when they lay side by side. The retropharyngeal space lies behind the pharyngeal musculature and extends to the skull base superiorly and to the tracheal bifurcation inferiorly. The parapharyngeal space, which lies lateral to the pharyngeal wall and medial to the mandible and parotid gland, communicates with the retropharyngeal space. (Figure 5) Because of the communication between these neck spaces, pus may readily spread from the parapharyngeal space through the retropharyngeal space down into the mediastinum.

Infection in the parapharyngeal space may arise from lymphatic drainage (of the tonsils, adenoids, neighboring teeth, parotid gland, pharynx, and middle ear) that travels through this space.[8] Abscesses may be caused by dental infections, needle injections for anesthesia, upper respiratory tract infections, tonsillitis and middle ear or mastoid disease.[9,10] Parapharyngeal space abscesses may be caused by extension from peritonsillar or retropharyngeal space abscesses. Symptoms include dysphagia and trismus. Medial displacement of the tonsils and oropharyngeal walls are observed. Neck fullness is present, but fluctuance is typically absent, because much soft tissue separates the skin and the abscess cavity.[9]

Parapharyngeal space abscesses are considered the most dangerous of all deep neck infections.[8] Pus may extend into the mediastinum by two different routes simultaneously. As mentioned above, an abscess may rupture into the retropharyngeal space and proceed inferiorly to the mediastinum. Secondly, pus may gravitate downward along the great vessels (carotid, jugular) that traverse the parapharyngeal space and enter the mediastinum.[10,11]

Diagnosis of these abscesses prior to advanced technology was limited to the history, physical examination and surgical exploration. Unlike retropharyngeal space abscesses, which are visualized and diagnosed on lateral neck films, (Figure 1) the parapharyngeal space is clearly visualized only on computerized tomography.[12,13]

Finally, the microbiology of deep neck abscesses reflects the oropharyngeal flora. Streptococcus, Bacteroides and Peptostreptococcus are the most frequently isolated pathogens in one series.[14] A pathogenic role for Bacteroides melaninogenicus has been implicated.[15]

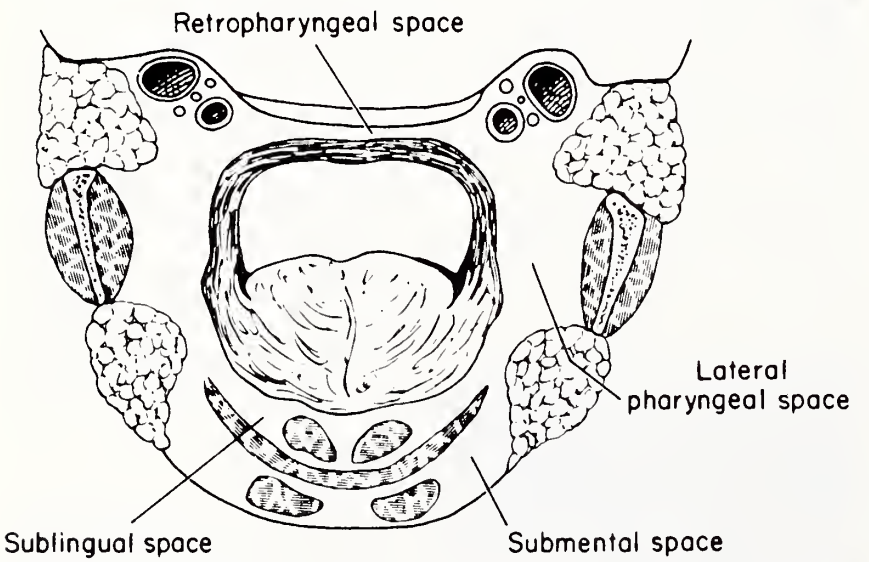


Figure 5.
Simplified schematic of the potential spaces of the deep neck. (Reprinted with permission from Diagnosis and Management of Deep Neck Infections by Daniel D. Rabuzzi, M.D. and Jonas T. Johnson, M.D. Copyright by the American Academy of Otolaryngology-Head and Neck Surgery Foundation, Inc.)

Conclusion

Tonsillopharyngitis is not always a benign process. In addition to rheumatic fever, suppuration into the neck, mediastinum and chest is possible despite adequate antibiotic therapy. Multi-organ disease such as A.R.D.S. and D.I.C. may further increase morbidity. A thorough understanding of the deep neck anatomy helps convey the pathophysiology of the spread of purulence from the neck to the chest. Bilateral neck and chest drainage and prolonged antibiotic therapy were necessary for this patient's recovery.

References

1. Holmberg, S.D., Faich, G.A.: "Streptococcal Pharyngitis and Acute Rheumatic Fever in Rhode Island," *JAMA* 250:2307-2312, 1983.
2. Levy, M.L., Ericsson, C.D., Pickering, L.K.: "Infections of the Upper Respiratory Tract," *Med Clin NA* 67:153-171, 1983.
3. McCue, J.D.: "Group G Streptococcal Pharyngitis–Analysis of an Outbreak at a College," *JAMA* 248:1333-1336, 1982.
4. Pratt, L.W.: "Infections of the Lymphoid Tissue," in English, G.M. (Ed.), Otolaryngology, Harper and Row, Philadelphia, Vol. 3, Chap 27: 19-24, 1983.
5. Rosenfeld, R.G., Jameson, S.: "Polymicrobial Bacteremia Associated with Pharyngotonsillitis," *J Ped* 93:251-252, 1978.
6. Bender, B.L., Madge, G.E.: "Fatal Myocarditis Associated with Acute Tonsillitis," *South Med J* 70:1005-1007, 1977.
7. Bass, R.M.: "Approaches to the Diagnosis and Treatment of Tumors of the Parapharyngeal Space," *Head Neck Surg* 4:281-289, 1982.
8. Gates, G.A.: "Deep Neck Infection," *Am J Otolaryn* 4:420-421, 1983.
9. Eliachar, I., Peleg, H., Joachims, H.Z.: "Mediastinitis and Bilateral Pyopneomothorax Complicating a Parapharyngeal Abscess," *Head Neck Surg* 3:438-442, 1981.
10. Pearse, H.E.: "Mediastinitis Following Cervical Suppuration," *Ann Surg* 108:588-611, 1938.

11. Moncada, R., Warpeha, R., Pickleman, J., *et al.*: "Mediastinitis from Odontogenic and Deep Cervical Infection–Anatomic Pathways of Propagation," *Chest* 73:497-500, 1978.
12. Holt, G.R., McManus, K., Newman, R.K., *et. al.*: "Computed Tomography in the Diagnosis of Deep Neck Infections," *Arch Otolaryng* 108:693-696, 1982.
13. Endicott, J.N., Nelson, R.J., Saraceno, C.A.: "Diagnosis and Management Decisions in Infections of the Deep Fascial Spaces of the Head and Neck Utilizing Computerized Tomography," *Laryngoscope* 92:630-633, 1982.
14. Wills, P.I., Vernon, R.P.: "Complications of Space Infections of the Head and Neck," *Laryngoscope* 91:1129-1136, 1981.
15. Brook, I., Gober, A.E.: Bacteroides Melaninogenicus–Its Recovery from Tonsils of Children with Acute Tonsillitis," *Arch Otolaryng* 109:818-820, 1983.

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Springfield Memo

(Continued from page 17)

Clinical Laboratory and Blood Banking Advisory Board

The Board has decided not to pursue a multi-tiered plan to regulate laboratory services provided in physician offices and other non-licensed ambulatory settings. Instead, the Board recommended that IDPH develop educational programs and materials to help non-licensed laboratories improve their quality assurance activities.
(Source: November 20, 1985 meeting of Clinical Laboratory and Blood Banking Advisory Board)

AIDS Interdisciplinary Advisory Council (AIAC)

On December 9, 1985, IDPH held the first meeting of its AIAC, which is presently made up of 25 members from a variety of state and county agencies, professional groups and concerned constituencies.

The overall purpose of the Council is to consider all problems concerning AIDS. The Council is to advise the governor and the legislature on what problems to address, what the state's priorities should be and how to allocate the state's limited resources. Eight subgroups were created to identify the problems and to suggest solutions and resources to meet those problems.

The Council will meet at least monthly through March 1986, and will submit a report by April 1, 1986, for consideration by the state.
(Source: December 9, 1985 meeting of AIDS Interdisciplinary Advisory Council)

From the Department of Rehabilitation Services (DORS)

The Department of Rehabilitation Services, formerly the Department of Vocational Rehabilitation (DVR), is offering a public awareness program called "Reaching Out." The purpose of Reaching Out is to enhance awareness of persons with disabilities, their employment potential and their roles as contributing members of their communities. This program consists of seminars on disability awareness and outreach.

Seminars can be tailored to meet the needs of physician or Auxiliary audiences, and can be run from 1-3 hours.

For additional information contact: Nancy Krafcik, Public Affairs, Department of Rehabilitation Services, 100 West Randolph, Suite 8-100, Chicago, IL 60601, (312/917-2922).
(Source: Correspondence from DORS Public Affairs Office.)

Carcinoid Tumor of the Lung

Case Report Presented by Raymond A. Dieter, Jr., M.D./Glen Ellyn

The Illinois Thoracic Surgical Society has agreed to furnish brief summaries of case reports related at their regular meetings. These case reports, published on a "space available" basis, are edited by Ralph Butz, M.D., assistant chief, thoracic surgery, Edward Hines Veterans Administration Hospital, Hines, Illinois.

This 60-year-old white woman had been seen two weeks prior to admission for what her attending physician considered a viral pneumonia. Chest x-ray at that time showed fluffy round infiltrates mainly in the left lower lobe. She had no history of night sweats, fever or weight loss. The only industrial exposure was in soldering at work. She was a nonsmoker with a history of 2 C-sections and a total hysterectomy. Physical examination revealed a blood pressure of 168/70 and a few scattered ronchi, more in the right chest than the left. The only other findings were scars on an obese abdomen. Chest x-ray at this time showed nodular densities in both bases (Figure 1). Laminograms demonstrated sharply outlined bilateral lesions of different sizes, more numerous in the left lower lobe (Figure 2). Bronchoscopy showed no abnormality. A duplication of the right renal collecting system appeared on the IVP. Pulmonary function studies showed some restrictive disease: FVC = 1.84, residual volume 0.58. Several subpleural nodules were removed for biopsy thru a left thoracotomy. These nodules "popped out" when the overlying lung was incised, suggesting encapsulation.

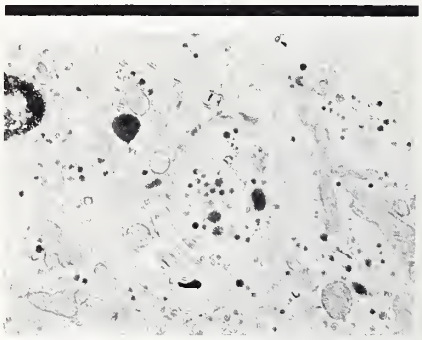


Figure 3.
Electron micrograph of lesion removed from left chest.

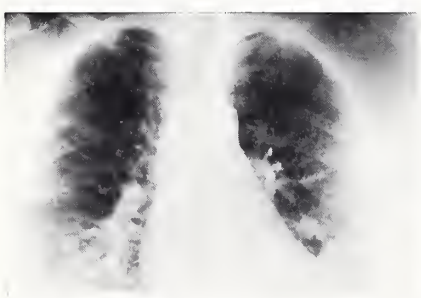


Figure 1.
PA chest x-ray showing nodular densities in both bases.



Figure 2.
Laminogram taken at the same time as Figure 1.

On H&E sections, nodules composed of fusiform cells having hyperchromatic nuclei were associated with stroma that varied in vascularity and hyalinization. There were occasional clusters within the vascular channels. Immunoperoxidase stains for insulin, glucagon, somatostatin, gastrin, VIP, and serotonin showed only serotonin, and that varied with the area of the tumor. Electron microscopy (Figure

3) demonstrated neurosecretory granules.

Guest Speaker

Z.V. Molnar, M.D., Ph.D., USVA Hospital, Hines, presented comments on the prognostic significance of morphology in carcinoid tumors of the lung with the role of electron microscopy.

The case presented illustrated a so-called carcinoid tumorlet of the peripheral lung and foci of fusiform cells and "gland" formation. Ultrastructural findings included many small, dense, core-type neuroendocrine secretory granules in the cell processes (Figure 3).

Typical carcinoid tumors of the lung generally are easily diagnosed. They are most often separated into centrally located bronchial carcinoids of uniform cell structure with large electron dense granules and the peripheral "tumorlets" with spindle cells and small dense core type granules. An ill-defined third group with worse prognosis is designated "malignant carcinoid."

Presently, based on retrospective studies of carcinoid tumors of the lung, certain morphologic criteria are recognized that separate the typical bronchial carcinoid tumors of relative good prognosis from the atypical ones of a higher malignant potential.[1-3] By light microscopy, the type of growth pattern, the presence of peripheral palisading in nests of tumor cells with central necrosis, presence of mitotic figures, "rosette" or "gland" formations and foci of undifferentiated carcinoma-like cells signify atypia. By electron microscopy these tumors may contain the dense core neuroendocrine secretory granules as in the oat cell carcinoma or have fewer than usual granules compared to typical carcinoid tumors which have characteristically abundant granules of either the small or large variety.

The atypical tumors may masquerade on light microscopy as small cell carcinoma of the intermediate type, poorly differentiated adeno or squamous cell carcinoma, small cell variant of squamous cell carcinoma, "typical" less aggressive carcinoid, or "typical" peripheral tumorlets. A close scrutiny of the light microscopy features is needed.[1-3] Fine structural studies with additional immunohistochemical studies[4] are often needed to clarify the true nature of these carcinoid tumors and to aid in treatment selection and establishing prognosis. ◀

References

1. Mills, S.E., *et. al.*: "Atypical Carcinoid Tumor of the Lung. A Clinical Pathologic Study of Seventeen Cases," *Am J Surg Pathol* 6: 643-654, 1982.
2. Johnson, L.A., *et. al.*: "Carcinoids: The Association of Histologic Growth Pattern and Survival," *Cancer* 51: 882-889, 1983.
3. Wise, W.S., *et. al.*: "Carcinoid Tumor of Lung with Varied Histology," *Am J Surg Pathol* 6: 261-267, 1982.
4. Yang, K., *et. al.*: "Pulmonary Carcinoids. Immunohistochemical Demonstration of Brain-Gut Peptides," *Cancer* 52: 819-823, 1983.

EKG

(Continued from page 14)

Answers: 1. C 2. E

The first few beats in leads I, II and III are sinus beats at a rate of 79 beats per minute, but the rest of the twelve lead ECG shows a supraventricular tachycardia at a rate of 170 beats per minute with slight variation in the cycle length best seen in lead V_6. The initiation of the tachycardia is not seen. P waves of the tachycardia are clearly seen in lead V_1 (bars) with PR intervals of 0.20 seconds. The PR interval of the sinus beats is 0.14 seconds and the P wave morphology of the sinus is different from the P wave of the tachycardia. Paroxysmal sinus tachycardia is thought to be a reentrant tachycardia within the region of the sinus node. Reentrant sinus tachycardia has a variable rate ranging from 80 and 150 beats per minute. The clinical clue is a sinus tachycardia with abrupt onset that is clinically inappropriate. In addition, P wave morphology is often similar to the sinus node P waves. Multifocal atrial tachycardia would have two or three or more distinct P wave morphologies. AV nodal reentrant tachycardia requires two pathways, one slow and one fast, conducting in a sequential fashion. This can involve two pathways in the AV node or an anomalous bypass tract. If there is no pre-excitation on the resting ECG, most of these tachycardias will be AV nodal reentrant.

The differential diagnosis of supraventricular tachycardias, AV nodal reentrant, concealed anomalous pathway, or sinus node reentrant tachycardias can be difficult. This young patient did not respond to digoxin or quinidine. To study this tachycardia, electrophysiology study was necessary. This study showed a high to low right atrial activation which suggested that the focus of this tachycardia was near the sinus node. Overdrive pacing, as well as the extrastimulus technique, failed to break the tachycardia. There was no retrograde ventriculo-atrial conduction, which ruled out AV nodal reentry. Four milligrams of IV propranolol slowed the tachycardia from 170 to 140 beats per minute, but did not eliminate it.

This tachycardia is an atrial ectopic or automatic tachycardia. Children with this tachycardia are a difficult management problem because digoxin is often ineffective.[1] In addition, quinidine and propranolol failed to control the tachycardia in our patient, although some slowing of the rate was achieved. Verapamil was our best choice, although complete control was still not achieved.[2] Two years later the patient stopped his medication and the tachycardia returned with similar symptoms.

References

1. Gillette, P.C., Garson, A.: "Electrophysiologic and Pharmacologic Characteristics of Automatic Ectopic Atrial Tachycardia," *Circulation* 56:571-575, 1977.
2. Porter, C.J., Gillette, P.C., Garson A., *et al.*: "Effects of Verapamil on Supraventricular Tachycardia in Children," *Am. J. Cardiol.* 48:487-491, 1981.

Cathartic Drugs And Pain In Pre-Industrial Europe

By Vincent J. Knapp, Ph.D., Potsdam, New York

Drugs were used liberally in European society prior to the Industrial Revolution. They were omnipresent, and readily available to the medical profession. In 1800, one Austrian publication listed a total of 293 drugs which had recently passed in and out of fashion.[1] In the 19th century, a well respected book on the history of pharmacology, published in England, recorded the use of no less than 2,743 drugs over the course of European history.[2] The situation had grown so far out of control at one point that the English observer William Rowley could only rave at this parapharmaceutical approach. He wrote that physicians had become alternately "Quicksilver mad," "Saltwater mad," "Digitalis mad," "Arsenic mad," "Nitric acid mad," and "Sugar of lead mad."[3]

Why were drugs so prevalent in Europe for such a long time? The best answer to date was that provided by Owsei Temkin a few years ago. In his article, "Historical Aspects of Drug Therapy," he insisted that the medical profession then viewed drugs as handy tools to eliminate widespread pain and disease in Europe's pre-industrial society. The profession viewed drugs as cathartics; as quick and efficient means to drive from the body what the great English physician Thomas Sydenham called "morbific matter."[4]

According to Temkin, drugs were seen as great cleansing agents with the power to purge humours of "morbific matter" which had somehow found their way into the juices of the human body.[5]

One of the most popular drugs, used to purify the body immediately, was mercury. Mercury was for centuries used as a purgative and a cure for syphilis. Medical men typically viewed its workings as mysterious. In the 18th century, the English doctor John Andree admitted, "The method in which mercury arrests this disease [syphilis] is not yet known."[6] But, he did not doubt its efficacy. Generally speaking, the medical profession's faith in the other drugs of the time was equally undaunted.

A Drug-Ridden Society

The use of cathartic drugs to bring about quick cures can be traced to the Middle Ages.[7] In the years after 1500, a period usually described as early modern times, the lexicon of drugs in use was almost limitless. Physicians experimented with drugs constantly, to the point where one knave could chastise them: "Let's hurry, hurry, use the new drug before it stops curing."[8]

While most doctors acted with moderation, a few could and did go overboard. Such a situation developed among the physicians resident at the Bamberg Hospital in Germany in 1798. In that year each of the 480 patients in the hospital's wards consumed an average of "1 dram of opium, 195g of camphor, 1 ounce of liquor, . . . 132g of serpentaria [a hydrous magnesium silicate], 528g of Peruvian bark [quinine], [and] more than 1 quart of distilled alcohol."[9] While this represents an extreme case of drug overdose, it also illustrates the options that were open to physicians who believed in actively prescribing these types of remedies.

In the European past, drugs were either derived from plants or from metallic substances. While thousands of drugs were at the disposal of both physicians and apothecaries, a few stand out as leading medicaments.

Over time, no drug in European history could approach the reputa-

tion that surrounded mercury. Soon after the introduction of malignant syphilis in the 1490s, mercury came to be regarded as a sure and unfailing cure for this disfiguring disorder. Even the great Italian physician Girolamo Fracastoro, the first man in Western civilization to enunciate the germ theory, believed that in treating syphilis, "most people do better by dissolving everything in quicksilver."[10] In fact, 250 years later, John Andree was still extolling this drug, declaring in unequivocal terms that "Mercury . . . is known by all skillful practitioners of the healing art, to be the only medicine which will cure the Venereal Disease."[11] When Jean Astruc raled against the use of mercury as a purgative, saying that it "always weakens and destroys the stomach, and prevents its faculties and . . . [brings] on violent vomiting, violent purging, dysentary, spitting of blood, fainting [and] swooning,"[12] very few paid any attention.

Other Cathartics

While mercury never really lost its favorable reputation, other cathartic drugs remained in vogue for only a short time. Saffron was such a drug, heralded for a generation as the cure for plague. Thomas Vicary was primarily responsible for bringing saffron to public attention in England and on the Continent. In 1586, he specified saffron as the key ingredient in his instant cure for plague. As he put it in his well-known plague recipe of that year:

> *Take . . . English Saffron, the weight of a half-penny, and a farthing worth of Graines, a quart of long Peppers, a penny weight of Dace [fish], and stale Ale, stampe your hearte and pound your Saffron, and mingle them together, and then drink it.*[13]

Almost 20 years later, the English government was still advocating saffron to prevent bubonic plague.[14]

At almost the same time, yet another drug, advertised as having the power to cure febrile disorders rather quickly, was also coming into style in Europe. This new drug was quinine from South America. In the 17th century, Thomas Sydenham looked upon this product as a virtual godsend, declaring that, "Jesuits' bark [as quinine was originally called] has been famous in London for the cure of intermittent fevers for upwards of five and twenty years and *that rightly.*"[15] Quinine was viewed almost instantly as one of the great cathartic drugs of the time, curing such disorders as typhus, malaria, tuberculosis and influenza. What was being treated, of course, in these instances, was a symptom and not the actual, underlying cause of disease.[16]

Digitalis was yet another drug which became popular in 17th and 18th century Europe. Digitalis was a vegetable product derived from foxglove, a commonly-grown plant in Europe. It was initially a folk remedy but soon passed into the medical lexicon. Like mercury, digitalis had great staying powers, and was used consistently decade after decade (for the most part erroneously). It was alternately used as a diuretic, as well as to treat epileptics, cases of dropsy, people suffering from wounds, and tubercular patients. Praising the drug, one of its many advocates declared in the 1780s: "Digitalis has remained for a long time one of the very few objectively effective drugs in our pharmacopoeia."[17] Only later, near the turn of the 19th century, was it finally discovered that this long-vaunted drug could also control heartbeat.[18]

Ranking next to mercury as one of the most significant of the metallic medicaments over time was antimony. It was the vital ingredient in the nationally-known plague recipe which the French government issued in 1720. This prescription carefully advised doctors to, "Take four pounds of Hungarian antimony—break into small pieces, . . . add one pound of the prepared liquor of nitre [saltpeter], . . . and one half gallon of rain water, [then] boil for two hours."[19] The resulting powder was allowed to cool and administered with some kind of liquid to those suffering from plague. The purpose of this decoction was to promote as much vomiting as possible and thus to rid the body of whatever "morbific matter" was bothering it.

The exact same motive was behind the steadily increasing use of calomel in the late 18th and early 19th centuries. Calomel, actually mercurious chloride, was initially prescribed as a purgative to treat victims of syphilis, and then later on, as a remedy for those suffering from cholera. Less harmful than other forms of mercury, this substance, nevertheless, had a very debilitating effect on the body.[20]

When Europe Was a Pain-Ridden Society

The above list of drugs used in the European past, while relatively short, is nonetheless indicative of the faith that physicians placed in some of the key remedies at their disposal. Of course, other drugs were also seen as possessing extraordinary curative powers at certain times. These would include china root, sasparilla, sassafras, caster oil, arsenic, cod-liver oil and guaiacum.[21]

This listing and categorizing could go on and on, but such an exercise does not really explain why doctors resorted to the use of cathartic drugs so often in the European past. The answer really lies in the situation they had to confront day-after-day and patient-after-patient. For not only was Europe a drug-ridden society, it was simultaneously a pain-ridden society, and one had a great deal to do with the other.

After the mid-14th century, one infectious disease after another found its way into Europe.[22] All too often, victims of infectious disease during this era suffered almost endlessly from excruciating pain. Without modern analgesics, the medical profession naturally sought to drive out the poison that was afflicting the patient and causing so much misery. It was almost certainly this desperate situation that gave birth to the use of cathartic drugs which were expected to end the illness quickly and decisively and eliminate the pain that the disease was causing.

The universal use of highly effective analgesics in modern society has definitely blurred our historic memory of what it was like to live in

a society where pain was both widespread and commonplace. Plague is a case in point to illustrate what life was really like at that time. After 1347, tens of millions of Europeans knew its multiple symptoms and its painful consequences. In the telling words of one observer, in addition to boils and bleeding it always caused:

> *an internal Heat, an extreme Anxiety and Depression of the Spirits, a restless Agitation of the Body, accompanied with a Fever, Pains of the Head and Stomach, Phrensy and Delirium; a conclusive Motion of the Tendons, and small Contraction of the Limbs . . . a fetid Scent proceeded from the Mouth and Skin. . . . The Bowels were likewise affected [by] the following symptoms: A malignant Diarrhea . . . with . . . a Propensity to Vomit.*[23]

Syphilis, which evidently came to the European continent in its malignant form in the 1490s, was also a disease that tormented literally tens of millions. What it was like to endure the symptoms of this disease was poignantly described by one of the great German Renaissance writers, Ulrich von Hütten. Writing about his recurring bouts with syphilis, he woefully explained that there were:

> *boils, sharp and outstanding having the consistency and quantity of acorns, from which came such foul humors, and so great a stench that whoever smelled it, thought himself infected. The colour of these pustules was dark green and the sight of them was more grievous to the patient than the pain itself; and yet the pains were as though one had laid in fire.*[24]

Proportionately, only a minority of the European population had to deal with the human consequences of plague and syphilis. The same could not be said of smallpox, for in the 18th century a full 85% of the population came down with this disorder. Smallpox was just as capable of inflicting unrelieved pain as were plague and syphilis. One chronicle reporting on this phenomenon declared: "It is shocking to hear the groans of the sufferers, to see parts of their bodies as if burnt, dissolving away and to smell the intolerable foetor of their putrid flesh."[25] Through the centuries, these painful symptoms remained remarkably similar. In the late 18th century, the English doctor Thomas Dimsdale pointed out that this disorder first caused mild and then intense pain. It all began, he said, with "a delirium, . . . restlessness, [a] disagreeable taste in the mouth, and a peculiar foetid taste in the breath." It culminated, he went on, in "nausea and vomiting . . . , together with great pains in the head, back and loins."[26]

Typhus and cholera were two other diseases present in Europe, but they existed at a lesser level, and actually claimed fewer victims than either plague, syphilis or smallpox. This last fact was little consolation to those who had to endure the debilitating consequences of typhus. One doctor in Antwerp, after treating this disease, complained of its alacrity, saying it always came on without warning and:

> *usually at the night time, with chills followed by heats; the patients complained at the same time of painful palpitations, headache, want of breathe, a sense of pressure or tightness in the region of the stomach and sickness. As [these] symptoms rose in intensity, a . . . sweat broke out . . . , accompanied by a spotted papular or vesicular exanthem [eruption].*[27]

If the dehydration caused by this disease became too extreme, the patient would ordinarily pass away. The same sort of fate awaited the victims of cholera. In the early 19th century, one Russian doctor could do little else than record the torment experienced by one of the very first Russians to have cholera. The physician had treated this person, a soldier, for diarrhea and cramps, but the patient's condition worsened. Writing about it, the doctor reported:

> *At six I found him . . . sensible, but with sunken pale-blue cheeks, dimness of the eyes, coldness of the feet and hands, and bedewed with clammy sweat. He was tossing about and complaining of trembling in the hands, a painful sense of oppression at the pit of the stomach, and intolerable thirst . . . The exhausted, powerless condition of the patient, in particular his completely imperceptible pulse, . . . left me no hope for his recovery . . . soon afterwards the man expired.*[28]

Without question, painful deaths were ordinary enough in the European past. This continued well into the 19th century, when tuberculosis gained a greater and greater foothold. Once again, generations of physicians confronted a horrifying disease and watched its agonizing consequences. Speaking of a patient who had been suffering from pulmonary tuberculosis in the 1790s, Thomas Beddoes could only express an underlying sympathy as he wrote that this man had had a "hard rendering cough, attended sometimes by retching and vomiting." He also recorded this man's other symptoms, which included:

> *the extremes of cold and heat through which he is carried by the daily returns of the hectic [fever]; the sweats in which he reposes by night [which] drenches him; [and his] . . . breathlessness on motion or without motion, [which arises] by degress to a sense of drowning and terminating in actual drowning when there is no longer any strength to bring up the fluids secreted by the chest.*[29]

Like hundreds of millions of other Europeans in the 19th century, the great English novelist Robert Louis Stevenson suffered continuously from the symptoms of pulmonary tuberculosis. But unlike others, he left a diary telling of his long, extended bout with the unmanageable pain caused by this disease. Speaking of his situation, he commented sadly:

I lie awake troubled by a hacking, exhausting cough, and praying for sleep or morning, from the bottom of my little shaken body. I have written in bed, and written out of it, written in haemorrhages, written in sickness, written torn by coughing . . . . the Powers have so ordained that my battle field should be this . . . [30]

Conclusion

Modern medical science has advanced to the point where doctors can now talk confidently about pain management. Their buoyancy in this regard is the direct result of the great scientific discoveries of the last century or so enabling them to use all kinds of analgesics, from aspirin to morphine and from meperidine to levorphanol.[31]

Physicians in the European past were never in that fortunate position. Pain was nearly always unstoppable and uncontrollable.[32] If physicians in the past looked to quick cures in the form of cathartic drugs, their sometimes exaggerated responses were to a certain degree understandable. Confronted with one disease after another, each of which caused excruciating pain, they inevitably sought those remedies that would not only cure the disease rapidly, but also liberate their patients from pain that was obviously too much for most of them to endure. ◀

References

For a complete list of references to "Cathartic Drugs and Pain in Pre-Industrial Europe" write to the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

Vincent J. Knapp, Ph.D., is affiliated with the State University of New York College, Potsdam, New York, as a professor of European history. Dr. Knapp, who was educated both in Europe and the U.S., has completed nearly 30 publications. He has most recently focused his work on European disease and dietary trends since 1700.

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This position is part time and offers competitive compensation and benefits. Please send your curriculum vitae in complete confidence to:

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c/o *Illinois Medical Journal*
Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602

MEMBERSHIP FORUM

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, Twenty N. Michigan Ave., Suite 700, Chicago 60602.

Aeromonas Hydrophila Not Uncommon In Illinois

Dear Sir:

We read with interest the article by Masear and Hill (*Illinois Medical Journal* 167:123-125, February, 1985). We wish to emphasize that infections with Aeromonas hydrophila are more common in Illinois than may be generally appreciated. Over the past three years, we have seen several well documented cases of wound infections caused by this organism. The most striking example occurred in a young adult male who suffered a scalp laceration when he fell on a boat launching dock at Lake Decatur. His subsequent clinical appearance and course were very similar to the patient described and photographed by Hanson, *et al.*[1]

We have also isolated the organism from the blood of an elderly female with micronodular hepatic cirrhosis secondary to long standing alcohol abuse. The association of Aeromonas sepsis with chronic liver disease has been well documented in the past.[2-4]

In addition, several of our patients with diarrhea have shown significant growth of the organism in stool cultures. We were not able to definitively establish that the isolated Aeromonas was etiologically related to the diarrhea. However, recent reports indicate the organism is a true enteric pathogen.[5-7]

Finally, we would like to remind laboratorians that Aeromonas may be easily misidentified as either Escherichia or Enterobacter species if the oxidase test is not routinely performed on *ALL* gram negative organisms which have colonial morphological features usually suggestive of a member of the family Enterobacteriaceae.

Sincerely,
Donald E. Matthieu, Jr., M.D.
H. Larry Penning, M.D.
Alan F. Frigy, M.D.
Alfred J. Kiessel, M.D.
Pam Brinkoetter, M.T.(ASCP)
Decatur

References

1. Hanson, P.G., *et al:* "Freshwater Wound Infection Due to Aeromonas hydrophila," *JAMA* 238:1053-1054, 1977.
2. Davis, II, W.A., *et al:* "Human Aeromonas Infections: A Review of the Literature and A Case Report of Endocarditis," *Medicine* 57:267-277, 1978.
3. McCracken, A.W., *et al:* "Isolation of Aeromonas Species from Clinical Sources," *Journal of Clinical Pathology* 25:970-975, 1972.
4. von Graevenitz, A., *et al:* "The Genus Aeromonas in Human Bacteriology," *New England Journal of Medicine* 278:245-249, 1968.
5. Burke, V., *et al:* "The Microbiology of Childhood Gastroenteritis: Aeromonas Species and Other Infective Agents," *Journal of Infectious Diseases* 148:68-74, 1983.
6. Gracey, M.: "Aeromonas-Associated Gastroenteritis," *Lancet* 2:1304-1306, 1982.
7. Rahman, A.F.M.S., *et al:* "Dysentery-Like Syndrome Associated with Aeromonas hydrophila," *British Medical Journal* 281:976, 1980.

Pneumopericardium and Asthma

Dear Sir:

I write in criticism of the article entitled "Pneumopericardium," which appeared in the *IMJ* in April, 1985, Vol. 167:4, page 311.

In my opinion, the radiographic findings on the chest films presented could all be explained by the patient's pneumomediastinum and are, therefore, not convincingly due to a coexistent pneumopericardium. Air within the mediastinum commonly projects along the left heart border, and can be observed beneath the heart, as well.

For those who might be interested, in his book, THE MEDIASTINUM,

Dr. E. Robert Heitzman provides us with anatomic correlations with the various positions air can occupy in the central portion of the chest. Incidentally, a simple left lateral decubitus film of the chest can differentiate air in the mediastinum from air in the pericardial sac—*i.e.*, if the air is contained within the pericardium, it will migrate up alongside the right atrial edge when the patient is positioned with the left side dependent.

The article is interesting and informative. I do not believe, however, that this case inarguably represents the English literature's "second case of pneumopericardium as a complication of asthma."

Sincerely,
Guy R. Matthew, M.D.
Chicago

The Authors Reply:

Dear Editor:

Dr. Matthew's criticism is valid and in the absence of other projections we cannot prove that the air seen in our patient's chest roentgram is pericardial. However, the lack of the "continuous diaphragm sign,"[1] the presence of a normal appearing pericardium (better seen in the original films), and the clinical findings are highly suggestive of pneumopericardium. We also agree with Dr. Matthew that pneumopericardium as a consequence of asthma is probably more common than is generally recognized, particularly among children with severe and inadequately treated disease. Nonetheless, our review of the English literature revealed only one previously published report.

Rif S. El-Mallakh, M.D.
Farmington, Connecticut
Nicholas V. Augelli, M.D.
Royal Oak, Michigan

Reference

1. Levin B: "The Continuous Diaphragm Sign—a Newly Recognized Sign of Pneumomediastinum," *Clin Radiol* 24:337-338, 1973.

DRG Compliance Does Not Provide Immunity

It has come to the attention of the ISMS Board of Trustees that, over the past year, some physicians have been informed by hospital chief executive officers, utilization review and/or DRG coordinators that they may be immune from professional liability actions when providing medical care if they have complied with or relied upon DRG norms, provided that they have exercised due care.

ISMS has been informed that some coordinators are relying upon language excerpted from Section 1153 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The language states:

"(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by an organization under contract pursuant to section 1153 operating in the area where such doctor of medicine or osteopathy or provider took such action; but only if . . .

(1) he takes such action in the exercise of his profession as a doctor of medicine or osteopathy or in the exercise of his functions as a provider of health care services; and

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment."

Subsequent to ISMS Board of Trustees review, physicians are advised that this section of TEFRA does not relieve them of the obligation to exercise due care in providing medical care to patients. As such, this section does not provide physicians with any meaningful immunity from professional liability litigation.

Additionally, physicians are advised that the Health Care Financing Authority has directed the Peer Review Organization for Illinois to stringently review all cases in which patients have been discharged early and/or physicians have been encouraged to discharge patients solely to meet DRG average length of stay parameters.

Physicians must continue to exercise sound independent medical judgment in providing care and discharge planning for their patients. Discharging patients solely on the basis of economic considerations, rather than sound independent medical judgment, may create significant legal and liability problems for physicians. ◀

1986

Election Activities Calendar

As a result of our dramatic success in 1985, many physicians and auxilians expressed the desire to continue their involvement in politics.

The 1986 election offers physicians and auxilians the opportunity to work with our friends in their efforts to remain in office or to work with candidates who oppose legislators whose views are not in line with those of medicine.

The calendar below presents many suggestions on how to get involved in a campaign. Take advantage of this opportunity to make a difference. Become involved in the 1986 elections.

JANUARY	FEBRUARY	MARCH	APRIL
Volunteer in a political campaign Sponsor Voter Registration Drive **Join IMPAC!**	February 10—Cut-off date for Voter Registration in primary Develop and send candidate support letter to the medical community	March 18—Primary Election Day **VOTE!**	Keep candidate informed on medical issues before the legislature
MAY	**JUNE**	**JULY**	**AUGUST**
Keep candidate informed on medical issues before the legislature	Keep candidate informed on medical issues before the legislature	Begin planning for a Voter Registration Drive, possibly in hospital	Work with candidate's staff to develop a schedule for candidate to tour hospital and attend medical staff meeting Hold candidate's night at county medical society or at auxiliary meeting
SEPTEMBER	**OCTOBER**	**NOVEMBER**	**DECEMBER**
Voter Registration Drive Display candidate literature in office Wear candidates' buttons in hospital and in office	October 7—Cut-off day for Voter Registration in general election Develop and send candidate support letter to medical community	November 4—General Election Day **VOTE!**	Invite winner to county medical society meeting to receive congratulations and establish Key Contact relationships

DOCTOR'S NEWS

RESOLUTIONS DEADLINE ANNOUNCED

The ISMS House of Delegates' annual meeting will convene Friday-Sunday, April 4-6, at the Westin O'Hare Hotel in Rosemont. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 5. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accord with House policy, resolutions will be published in the *Journal* by author and subject only. Resolutions received in the ISMS offices by an earlier deadline, February 3, will be published in the February issue of *IMJ*.

GOVERNOR DECLARES JANUARY EYE HEALTH CARE MONTH

In conjunction with similar federal action, Illinois Governor James R. Thompson has declared January to be Eye Health Care Month in Illinois. The governor's declaration states that Illinois citizens "should become aware of the importance of eye health care and seek direct help from medical eye doctors when eye conditions that may lead to blindness are experienced."

PHYSICIANS IN THE NEWS

Dr. Vincent A. Costanzo, Jr., Lansing, has been honored by the Illinois Pharmacists Association as its 1985-86 honorary president. Dr. Costanzo, who chairs the Illinois State Medical Society Committee on Drugs and Therapeutics, was cited for his role on the Technical Advisory Council of the Drug Product Selection Program administered by the Illinois Department of Public Aid. His unique credentials as both a pharmacist and physician were noted as contributing to better interprofessional relations among physicians and pharmacists. Dr. Costanzo is director of the Jackson Park Hospital Family Practice Center in Chicago.

Dr. Sidney Black, Glencoe, has been elected a governor of the American College of Surgeons. A Fellow of the College since 1953, Dr. Black is past president and past secretary-treasurer of its Chicago chapter. He is clinical professor of surgery at the University of Illinois College of Medicine.

PHYSICIANS WITH EQUIVALENT DEGREES ABLE TO USE MD DESIGNATION

Under a bill signed by Governor Thompson, any licensed physician may use the designation "M.D." if he or she has graduated from a medical college with a degree recognized as equivalent to "Doctor of Medicine" or "M.D." While the Department of Registration and Education routinely printed M.D. after a physician's name in the medical license issued to duly qualified and registered physicians who graduated from foreign medical schools, the practice was never ratified by Illinois law. Dr. Ramesh C. Tripathi, a professor of ophthalmology at the University of Chicago and co-chairman of the Association of Indians in America's Council of Medical Affairs, was especially active in gaining support from the Department of R&E.

REHABILITATION WEEK SET FOR APRIL

A springtime world conference on rehabilitation is scheduled to be held in New York City. Designed to help accelerate the restoration of disabled people and their reintegration into active life, the April 6-9 meeting marks the first time that International Rehabilitation Week will be held in the United States. The event will feature an exposition of products from U.S. and foreign companies; a conference with the participation of international leaders from the fields of medicine, science, technology, vocation, and education for handicapped people; and a symposium and workshops on ameliorating disability. For further information, contact EJJ Management, Inc., 225 W. 34th St., Ste. 905, New York, NY 10122, (212) 563-5461.

GET WELL WISHES FOR ISMS MEMBERS

The Illinois State Medical Society has available a mechanism to extend get well wishes to ailing physicians. Persons who are aware of a member who is not well and who might appreciate a greeting from the Society are encouraged to advise the division of membership/marketing at ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602, (312) 782-1654. ◀

MECO

By Blaine A. Markee, Chicago
1986 Illinois MECO Project Director

As the end of the first year of medical school comes into view, students begin to contemplate how they will spend what could be their last free summer. The options are many. One option is particularly good for the student who has not had much clinical exposure or who desires more exposure before the formal clinical years of medical school begin. This option is the MECO program, which offers the opportunity to observe first-hand the daily activities of practicing physicians.

MECO (Medical Education-Community Orientation) is a summer program which exposes student externs to the practical facets of the different specialties, as well as the roles of the many people involved in the practice of medicine and the operation of a hospital. This experience can help some students to make more informed career decisions.

Initiated in Illinois in 1969, the MECO program now comprises a network of community-based educational programs for pre-clinical students in over 35 states. These summer externships in community hospitals and with private physicians, offer a unique educational experience which is not available in specialty-oriented urban and university teaching hospital curricula. Participants are exposed to both clinical and non-clinical areas of the hospital. They are able to observe and participate in physicians' offices, study the function of health-related agencies and institutions within the community (*e.g.*, nursing homes, drug rehabilitation centers, planned parenthood organizations, and ambulance services). The program emphasizes the study of patient-oriented health care delivery and the relationship of the patient to the total health care system.

MECO is sponsored and administered by the Illinios State Medical Society's Medical Student Section. It is hospital oriented in Illinois, organized around the concept of mini-clerkships and the rotation of the student through the various hospital departments (surgery, medicine, pediatrics, pathology, radiology, etc.). Students have the opportunity to make rounds with physicians, assist in the OR and delivery rooms, observe outpatient examinations and procedures, attend hospital conferences and observe other hospital business.

Since the program was initiated, more than 8000 students have participated in MECO across the country. The goals and objectives are multifaceted. The program is designed to introduce students early in their medical education to primary care medicine in a community atmosphere and to the cultural, economic and environmental determinants of health. It is hoped that this exposure will raise awareness of the grave need for physicians in underserved areas and the increasing demand in general for quality, community oriented, primary care medicine. Additional goals of MECO are the following:

*To introduce the student to operation and organization of community health care institutions and their inter-relationships with the delivery of health care in a community.

*To introduce the student to the roles of other health care professionals and the interplay between these individuals and their fellow physicians.

*To introduce the preclinical medical student to the clinical aspects of medicine, smoothing the transition from the classroom to the clinic.

*To provide the student with an opportunity to take an active part in the planning of his own educational experience.

*To provide the student with some insight into the field of medicine he or she would like to practice.

*To introduce the student to the multiple opportunities for continuing medical education and practice in a non-academic setting.

MECO affords numerous advantages to the local community and participating hospital and/or physician(s). Studies have shown that a statistically significant number of students have either returned or stated that they would return to the locale of their MECO program. For many physicians, a major appeal of the program is the satisfaction gained through participation in the medical education of future physicians and the stimulation provided by the students' presence.

ISMS is always searching for additional hospitals and physicians wishing to participate in the MECO program. Community hospitals that are not primary university teaching hospitals, community physicians and group practice clinics are ideally suited.

In general, students receive an educational stipend of approximately $100 per week and possibly room and board. This funding is provided by the hospital where the student is based.

For further information, please contact the MECO Project Director, Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois, 60602, or contact 312-782-1654 and ask for the Medical Student Section. ◀

Should We Let Our Teens Drink?

By Cheryl White, R.N.

Substance abuse is a common denominator in many of the serious problems teens face today. Our world is changing rapidly, and when things get difficult, some teens, like some adults, turn to alcohol or other drugs as a temporary solution. Why do people turn to alcohol and other drugs? They do it because it feels good, and everyone wants to feel good.

It is especially harmful for teens and preteens to use alcohol. There are several reasons for this. For one thing, it is illegal. In order to drink, teens must learn how to lie, and how to acquire, hide and use an illicit substance. Second, the effect of alcohol on the adolescent body is different from the effect on the adult body. It takes an adult an average of 5-15 years to become an alcoholic. It can take a teen only 6-18 months, and a preteen only 3 months, to become addicted. The developing body and mind of a young person is very vulnerable to harm by alcohol and other drugs. Teens who use alcohol at parties every weekend are in stage three of alcohol use. The stages are experimentation, occasional use, regular use, and dependence or alcoholism.

A third reason why teens should not use alcohol is that its use interferes with the developmental tasks of adolescence. These tasks include physical, mental, social, emotional and spiritual maturation. Teens must learn how to interact with each other, how to handle social situations, how to accept responsibility, how to cope with problems, how to be loving and giving, etc. If they dull their senses to what is happening around them, they cannot develop properly.

By definition, adolescents are in the process of maturing. They are not mature at age 13 or 15 or 16. It is unrealistic for us to expect "adult" behavior from them. We want to, and can, trust them. We can trust them to act their age. If they are 13, we can trust them to act 13. If they are 15, we can trust them to act 15. It is unrealistic for us to expect adolescents to act like adults.

It is very easy for our teens to fall into unhealthy patterns of drug and/or alcohol use. Years ago, it was easy for our children to get polio, diphtheria or measles. Then we began to practice prevention with our children in the form of inoculation. Today these illnesses are far less common. We can do the same with alcohol and drug use. We can use the inoculation for this. It is called prevention.

Prevention is something we do before our children are forced to make drug or alcohol use choices. We do it *before* our children start attending parties, *before* they start drinking or using drugs, *before* we realize we have a problem.

One very important area that can be addressed in prevention is the development of parent peer groups. This can be a group of parents from your teens' friendship circle or parents of teens in your child's grade level. These parents join together to discuss and agree upon certain guidelines, such as opposition to drug and alcohol use by teens, appropriate curfews and supervised parties. Parents who join together in this way can give each other support so that they can feel stronger while limiting their children's unhealthy activities. A parent peer group starts when one parent finds another parent with whom he shares certain ideas about limit setting and other related values. As with other prevention activities, this works best before teens start drinking or using drugs. The strange thing about prevention is that by the time we think we need it, it is too late to use it.

There is a lot we can do to help our teens avoid the dangers of sub-

(Continued on page 43)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

FEBRUARY

Allergy/Clinical Immunology

Case Presentations

February 23, 8:30 a.m., Holiday Inn City Centre, Chicago. **Sponsor:** The Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 4½ hrs. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

OB/GYN/Family/Emergency Medicine

Medical Seminar at Sea (Caribbean Cruise)

For: Physicians. February 7-23. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $600. **Credit:** Category 1: 60 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Nutrition

Clinical Nutrition in Office Practice

For: Family practitioners, internists, pediatricians, nurse practitioners and dieticians. Lecture/Workshops, February 6, Urbana, IL. **Sponsors:** Carle Clinic Association/Carle Foundation Hospital and University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $40. **Reg. Limit:** 80. **Credit:** Category 1: 6 hours; AAFP: 6 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3022.

Perinatal Medicine

4th Annual Meeting of Perinatal Association of Illinois

February 6, 12:45-4:15; February 7, 8:30-3:45; February 8, 8:30-12:00, Schaumburg, IL. **Sponsor:** University of Illinois College of Medicine. **Fee:** $95 (members); $125 (nonmembers). **Credit:** Category 1: 9 hours. **Contact:** Bruce A. Work, Jr., M.D. **Phone:** (312) 996-7430.

Gynecology

Urinary Problems in the Practice of Gynecology

For: Gynecologists. Symposium, February 8, Holiday Plaza Complex—Matteson, IL. **Sponsor:** University of Chicago, 5841 S. Maryland, Chicago, IL 60627. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Pediatrics

Instructional Workshop on the Adolescent Pelvic Exam

For: Pediatricians. Workshop, February 8 and 22, noon. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60627. **Fee:** $25. **Reg. Limit:** 20. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine

Advances in Family Medicine

For: Physicians. February 17-21, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $500. **Reg. Limit:** 90. **Credit:** Category 1: 38 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800)621-4649 in Illinois; (800) 621-4651 outside Illinois.

Family Medicine

17th Family Medicine Review

For: Family physicians. Course, February 23-28, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $425 (after Feb. 10th-$450). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; **AAFP Prescribed:** 50 hours. **Contact:** Rosemary Fischer; **Phone:** (606) 233-5161.

Surgery

Specialty Review in General Surgery Part II

For: General and specializing surgeons. Lecture, February 17-28. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $840. **Reg. Limit:** None. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Emergency Medicine

Winter Symposium

For: Emergency physicians, emergency nurses, and paramedics. Symposium, February 21-23, Lake Geneva, WI. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Fee:** $100-200. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

MARCH

Oncology

Fourth Annual Oncology Symposium

For: Physicians. **Date:** To be determined, Springbeld, IL. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Credit:** Category 1: Hours to be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Unique Seminars

The "Leadership" seminar assists the medical leadership in understanding the basic elements of effective CME planning. Participants will gain a foundation of skill in group techniques to involve medical staff members in CME planning and in how to start the systematic effort that leads to effective CME in the hospital setting.

The "Evaluation of CME Process" seminar provides the medical leadership with the practical information to apply the purposes of evaluation to program administration, faculty performance and participant learning. The leadership will discuss various common techniques used in the evaluation process for the development and implementation of quality CME programs.

For further information about participating in a unique ICCME seminar, please contact the Illinois State Medical Society, Twenty North Michigan Avenue, Chicago Illinois 60602 (312-782-1654).

Otolaryngology
Decisions in Diagnosis and Management of Nasal and Sinus Disease
For: Otolaryngologists. Course, March 23-28, Vail, CO. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** 50. **Credit:** Category 1: 22 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Cardio-Disease/Physics/Medicine
Medical Seminar at Sea (Caribbean Cruise)
For: Physicians. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $400. **Credit:** Category 1: 36 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Neurology
Neurology Symposium
For: Physicians. **Date:** March 21. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Fee:** None. **Credit:** Category 1: 9 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Pathology
Current Concepts on Thyroid Tumor Pathology
For Pathologists. March 17, 7:00 p.m., Drake Hotel, Chicago, IL. **Sponsor:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Psychiatry
Comprehensive Psychiatry Review, Part I
For: Psychiatrists. March 17-22, **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $500. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Mary Ann Dillon. **Phone:** (312) 962-1056.

Pulmonary Medicine
Symposium on Chronic Obstructive Pulmonary Disease
For: Physicians and allied health personnel. Conference, March 6-7, Madison, WI. **Sponsor:** University of Wisconsin-CME, 465 WARF Bldg, 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 14 hours; University of Wisconsin CEUs: Approx. 14 hrs. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Sports Medicine
Second Annual Sports Medicine Conference
The Amateur Athlete: The Young and Mature
For: Interested physicians. Conference, March 12, 8:00 A.M.-4:00 P.M., Rockford, IL. **Sponsor:** University of Illinois College of Medicine at Rockford, 1601 Parkview Avenue, Rockford, IL 61109. **Fee:** None. **Contact:** Patricia Krusiec. **Phone:** (815) 987-7140.

APRIL

Allergy
The Relationship of Respiratory Infections to Asthma
For: Physicians. Lecture (dinner meeting), April 21, 6:00 p.m., Chicago, IL. **Sponsor:** The Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane K. Kubis. **Phone:** (312) 255-1024.

Ophthalmology
8th Annual Midwest Glaucoma Symposium
For: Ophthalmologists. Symposium, April 11-12, 8:30 a.m.-5:30 p.m., Chicago, IL. **Sponsor:** The University of Illinois College of Medicine at Chicago, Department of Ophthalmology, and Northwestern University. **Fee:** $225 for physicians, $100 for residents. **Reg. Deadline:** March 28. **Reg. Limit:** 250. **Credit:** Category 1: 12 hours. **Contact:** Sue Korienek, The University of Illinois at Chicago, Conferences and Institutes, 912 S. Wood St., 2N, Chicago, IL 60612. **Phone:** (312) 996-8025.

10th Annual Ophthalmology Current Concepts Seminar '86
For: Ophthalmologists. Conference, April 10-12, Madison, WI. **Sponsors:** University of Wisconsin-Madison, Department of Ophthalmology, and School of Medicine, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: approx. 18 hours; University of Wisconsin CEU's: approx. 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Emergency Medicine
Illinois ACEP 1986 Scientific Assembly
For: Emergency physicians, nurses, paramedics, pediatricians and family practice physicians. April 11-13, The Hamilton Hotel, Itasca, IL. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Fee:** $90-$250. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Advanced Trauma Life Support Provider Course
For: Physicians. Symposium, April 2-3, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Fee:** $350 for physicians and $200 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Neurology/Biology/Basic Sciences
Ninth Annual Midwest Neurobiology Meeting
For: Physicians. Symposium, April 4-6, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** To be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Gynecology
Current Management of Problems in Gynecology and Gynecologic Urology
For: Ob-Gyn's. Course, April 11-12, Knickerbocker Hotel, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $225. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, ACOG: 10 Cognates. **Contact:** Marlene Goldberg, **Phone:** (312) 962-1056.

Pathology
Recent Advances in Hematology
For: Pathologists and hematologists. Symposium, April 14, 7:00 p.m., Drake Hotel, Chicago, IL. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** (members only) Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Avenue, Chicago, IL 60644.

Cleft Lip/Palate
Cleft Lip and Palate: A 1986 Perspective
For: Physicians. Course, April 4-5, 9:00 a.m.-4:00 p.m., Chicago, IL. **Sponsor:** Center for Craniofacial Anomalies, University of Illinois at Chicago, P.O. Box 6998, Chicago, IL 60612. **Fee:** $150 for physicians and $100 residents/students. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marcia Aduss at above address.

Pediatrics/Family Medicine
Contemporary Pediatrics for the Practicing Physician
For: Pediatricians and family physicians. Course, April 18-19, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg, Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, **AAFP Prescribed:** 10 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Internal Medicine/Family Medicine
Aggressive Management of Diabetes and Obesity
For: General internists and family physicians. Course, April 11-12, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 11 hours. **AAFP Prescribed:** 11 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Clinical Endocrinology for 1986
For: Family practitioners. Symposium, April 5, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $60. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Pulse

(Continued from page 41)

stance abuse. This job could be seen as overwhelming, but I do not think it is. We can act individually or as a part of a group or organization, such as our state or local medical society or auxiliary. As individuals we can get involved in whatever prevention programs or citizen groups are available in our community. As parents we can deal with this issue in our homes. We can work through our school's parent club, suggesting a meeting for parents with a speaker on the subject. We can work through the schools to encourage special programs and speakers for the students, and we can encourage the administrators of our school districts to implement a kindergarten through twelfth grade curriculum. Much of that curriculum would not appear to be about drugs or alcohol, but would cover things such as self esteem, decision making skills, communication skills and problem solving skills.

Any little bit that any one of us could do in any one of these areas would help. I think the time has come for this issue to be addressed. More and more people are becoming aware of the problem and of others who share the same concern. It may be time for families of the medical community to be leaders in guiding our teens to more healthy leisure time activities.

The Sangamon County Medical Society Auxiliary has been distributing to parents in that county a brochure called "PARTIES—A Practical Guide for Parents and Teens." For copies of this brochure, please write to Mrs. Neville White, 1100 Woodland Avenue, Springfield, Illinois 62704. ◀

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:
Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

CARBONDALE:
Multi-specialty group needs the following physicians—allergist, pulmonologist, otolaryngologist and orthopedist. Contact: Wayne Given, 2601 West Main Street, Carbondale 62901, (618) 549-5361. (12)

GLEN ELLYN:
Full or part-time radiologist—Position in 60-physician, multispecialty, outpatient facility for radiologist. Facilities include fluoroscopy, tomography, mammography, diagnostic ultrasound, plus general radiology. Salaried position with excellent fringes, excellent workload and hours in comparison with hospital setting, plus the ability to work with a quality leading group in a pleasant suburban environment. Send CV to: Glen Ellyn Clinic, 454 Pennsylvania Avenue, Glen Ellyn 60137. (12)

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On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MONMOUTH:
Internist or family practitioner to join a practice in a small town. Terms negotiable. Please send curriculum to P.O. Box 183, Monmouth 61462. (12)

Viewbox

(Continued from page 7)

Diagnosis: Villous Adenoma of Duodenum

The villous tumor of Patient 2 is nonspecific in appearance and looks like a pancreatic lesion. The villous tumor of Patient 1, however, has the typical reticular appearance of a villous tumor. This appearance does not occur in the other choices.

Villous tumors occur throughout the entire gastrointestinal tract. They are by far most common in the colon and rectum, but also occur in the upper gastrointestinal tract, most often in the stomach. In one series of 92 villous adenomas outside the colon, 82 were in the stomach and 10 were in the small bowel.[1] Approximately 100 villous tumors of the stomach have been reported[2] but less than 50 in the duodenum.[3]

Pathology

In a total of 1,346 consecutively collected gastric resection specimens, 116 had hyperplastic polyps and 11 had adenomatous polyps. It has been suggested that 99% of all epithelial gastric polyps are hyperplastic or adenomatous.[4] Hyperplastic polyps are not dysplastic, because cellular atypia is lacking. They do not become malignant.

Adenomatous polyps show varying degrees of dysplasia. They have a high incidence of malignant transformation. Adenomatous polyps of the stomach are most commonly found in the pylorus and may be sessile or pedunculated. They may become quite large. The largest reported lesion was 21 × 15 × 10cm.[2]

Histologically, gastric adenomatous polyps are divided into three groups just as in the colon: (1) tubular; (2) tubulovillous and (3) villous.

Tubular lesions show proliferation of gastric epithelial cells, which are arranged in a regular tubular fashion, parallel to the muscularis mucosa.

The villous pattern is made up of frond-like projections with a slender fibrovascular core and covered by surface epithelium. With malignant transformation, there are abnormal nuclei, hyperchromatism, mitotic figures and architectural derangement. The epithelial surface is classified according to the degree of dysplasia present. This may be mild, moderate or severe. In a review of 455 resected gastric carcinomas, 25 were judged to be malignantly transformed adenomas and all had severe dysplasia. These tumors can recur and metastasize. They spread by local, hematogenous and lymphangitic routes.

The reported rate of malignancy in duodenal villous adenomas is 20.5-30.5%.[5] There is an increased incidence of malignancy as they are more distally located.[6]

It should be noted that the superficial portions of these lesions may be benign. Malignant change begins deep in the center of the tumor at the base. This is important when considering endoscopic biopsy reports.

Clinical Presentation

Symptoms and signs are closely related to the size and position of the tumor. In a series of 53 gastric villous tumors, Walk found 75% complained of weakness, 64% weight loss, 50% ulcer-type pain, and 30% nausea and vomiting.[7]

Duodenal lesions may cause gastrointestinal bleeding, obstructive jaundice, duodenal obstruction and vague upper abdominal symptoms.

Laboratory features include anemia, achlorhydria, and hemocult positive stool. Serum electrolytes are usually normal.

Radiological Features

The appearance of an upper gastrointestinal villous adenoma varies according to location and size. The classic "soap bubble" appearance produced by barium trapped between tumor fronds is most commonly seen in tumors of the stomach. In the duodenum they may present as nonspecific "mass lesions," (Fig. 2) but occasionally they have the typical appearance of a villous tumor (Fig. 1).

Management and Prognosis

Gastric lesions are removed with wide excision and removal of local lymph nodes.[1] If a villous adenoma is found by endoscopic biopsy, excision is indicated. Endoscopic resection is not recommended, however, unless the lesion is pedunculated and small.[8]

Noninvasive duodenal lesions can be managed conservatively by submucosal resection via lateral duodenotomy.[3] Frozen section is mandatory, as 21% of these lesions show frank malignant changes and 14% show "in-situ" changes.[3] The optimal management for invasive or *in situ* lesions is pancreatoduodenectomy.

Williamson reported two patients with malignant villous tumors of the duodenum treated by pancreatoduodenectomy.[9] One patient is alive and well seven years later, and the other 10 years after surgery. ◀

References

1. Bremer, E.H., Battaile, W.G., Bulle, P.H.: "Villous Tumors of the Upper Gastrointestinal Tract," *Am J Gastroenterol* 50:135-143, 1968.
2. Burnett, K.R., Keyser, B., Tomasulo, J., Edwards, K.C.: "Giant Gastric Villous Adenoma," *Am J Gastroenterol* 74:368-373, 1980.
3. Newman, D.H., Doerhoff, C.R., Bunt, T.J.: "Villous Adenoma of the Duodenum," *Am Surg* 50: 1, 26-28, 1984.
4. Sherlock, P., Morson, B.C., Barbara, L., Veronesi, U.: Precancerous Lesions of the Gastrointestinal Tract. Raven Press, New York, 1983.
5. Everett, G.D., Shirazi, S.S., Mitros, F.A.: "Villous Tumors of the Duodenum," *Am J Gastroenterol* 75:376-379, 1981.
6. Spira, I.A., Wolff, W.I.: "Villous Tumors of the Duodenum," *Am J Gastroenterol* 67:63-68, 1977.
7. Walk, L.: "Villous Tumors of the Stomach," *Arch Inter Med* 87:560-569, 1951.
8. Reddy, R.R., Schuman, B.M., Priest, R.J.: "Duodenal Polyps: Diagnosis and Management," *J Clin Gastroenterol* 3:139-145, 1981.
9. Williamson, R.C.N., Welch, C.E., Malt, R.A.: "Adenocarcinoma and Lymphoma of the Small Intestine," *Ann Surg* 197: 2, 172-178, 1983.

Are You Getting What You Paid For?

By Irene Borders, CMA

Doctor, in this never ending fast track world we are living in today, each member of your staff must be able to assume greater office responsibilities and to step ahead by demonstrating total commitment to his or her career.

The only way you can be sure that your medical assistant stays knowledgeable on all new methods of our modern medical system is to make sure that he or she continues with continuing education courses in all phases of your specialty field.

The Illinois Society, American Association of Medical Assistants, offers courses in anatomy and physiology, professional law and ethics and the humanistic medical assistant. These courses are taught by professionals with excellent qualifications.

The Illinois Society offers seminars and travel courses throughout the state during the year. Members obtain certification by examination. Continuing education units (offered through the seminars and travel courses) can be obtained and applied toward revalidation of their certification. Revalidation is not mandatory, but it is strongly recommended every five years.

Lectures and guided study courses are now being offered by our local chapters. These courses are presented by professionals qualified in a specific field. Continuing education units can be obtained.

A certified medical assistant in the physician's office can increase overall efficiency. Continuing education courses can keep him/her updated in all aspects of office procedure.

I cannot stress enough how important it is to have certified people. In some states, certification is mandatory. It is entirely possible that it could become mandatory in Illinois also.

I have been certified since 1975, and have come to realize that this is a never-ending learning process. Medicine and procedures have changed dramatically in the past ten years. We must encourage our medical assistants to keep up their education.

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Information regarding the Illinois Society and/or medical assisting can be obtained from Ehlma Garcia, CMA, EMT-A, President, Illinois Society, 6134 South Tripp, Chicago, Illinois 60629; Robin Bluestein, CMA-C, Co-Chairman, Public Relations Committee, 2247 West Estes #2, Chicago, Illinois 60645, or Catherine M. Hill, CMA, Co-Chairman, Public Relations Committee, 900 South Plum Grove Road, Palatine, Illinois 60067. ◀

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U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Psychiatry, Orthopedic Surgery, Cardiology, Allergist, Family Practice, and Internal Medicine. For further information call collect: 1st Lt. Michael V. Vivoda: (312) 263-1207.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

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ISMS Initiates New Public Service

Your Health Matters

Responding to the public's thirst for authoritative health information, the Illinois State Medical Society has launched a monthly health column for syndication to Illinois newspapers. The column, "Your Health Matters," is designed to provide readers with practical, informative commentary on key medical issues.

The column, authored by appropriate physician experts, is offered to more than 600 weekly newspapers in Illinois. It also is being test marketed to an additional 85 papers with daily circulation.

The column was started in October, and the first topic examined was Halloween safety. ISMS President-Elect Dr. Jere E. Freidheim, a Chicago pediatrician, authored the Halloween column. He offered advice on costumes and masks, safe trick-or-treating practices, and proper Halloween treats.

"Physicians throughout the state are concerned that holiday safety sometimes is not the priority that it should be," Dr. Freidheim wrote. "Despite the fact that this evening is supposed to be strictly fun-filled, each year children are unnecessarily injured or killed because of failure to consider a few easy precautions."

The November column addressed the issue of substance abuse. Dr. Violet Eggert, who chairs the ISMS Ad Hoc Committee on Substance Abuse Education, offered suggestions on how to recognize substance abusers so they can be helped. "The problem affects everyone," wrote Dr. Eggert. "The families of substance abusers and all of society pay a high toll in psychological, physical and health care costs: loss of productivity and wages, increased health care bills, accidents causing injury and death, violence and crimes to support drug habits are but a few."

Dr. Eggert detailed physical and psychological symptoms that might be exhibited by a substance abuser, and she advised family members or friends recognizing those symptoms to see their physicians for guidance and to arrange treatment.

To date, response to the new ISMS column by newspapers has been encouraging. Society members with suggestions on future topics for columns should contact the ISMS Division of Public Relations. ◀

TRANXENE®
(clorazepate dipotassium) ©

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for seveeral months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbituates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant.

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCE

1. Data pooled from 19 studies recorded as part of original Tranxene New Drug Application. 546 patients under treatment for anxiety were analyzed. 387 with baseline HARS 18 or greater entered in study. Following 7-day placebo lead-in period, patients in drug group (n = 235) received Tranxene® (clorazepate dipotassium) 7.5 mg for 21 days. Data on file, Abbott Laboratories.

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A Mirror of the Membership

This month we have a special issue devoted to membership. The *Journal,* of course, is one of the more visible membership benefits. Each month, it communicates the business of the Society and clinical developments of medicine in Illinois.

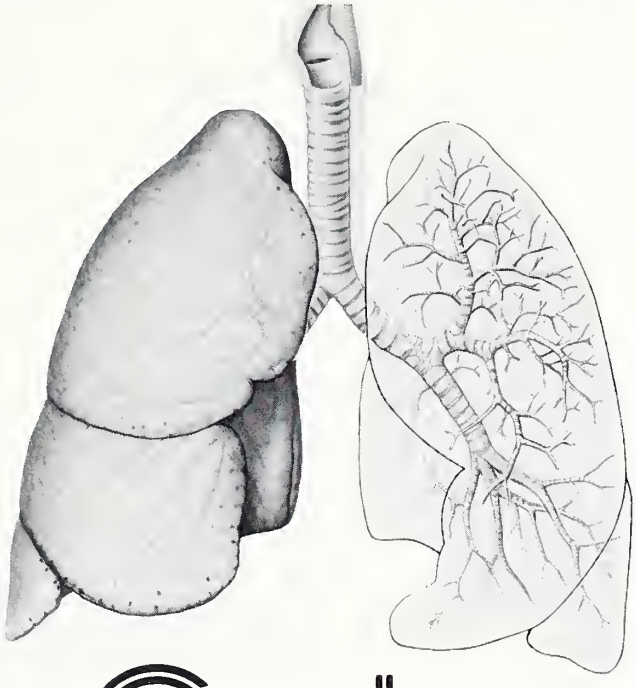
The Society's councils and committees focus on health care needs, legislation, regulation and professional concerns indigenous to Illinois medicine. The strength of the Society—and its journal—is that each draws on a wide spectrum of resources working together.

The *Journal* attempts to focus on material which reflects areas we have in common as Illinois physicians, rather than that which pertains to only one specialty or type of practice. Clinical contributions must strike a balance between what is novel to the specialist and what is useful to the generalist.

One theme of this issue is that the success of the Society's endeavors is determined by membership input. Your journal is a forum to explore our commonality and to share clinical information with other specialists. I hope that each member will consider submitting a manuscript for publication in the *IMJ.* Please encourage your colleagues, students and residents to do the same. Like the Society as a whole, your journal is what you make it.

J. William Roddick, Jr., M.D.
Chairman
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Consider the causative organisms...



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(ampicillin-susceptible) **(ampicillin-resistant)**

Brief Summary: Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor* (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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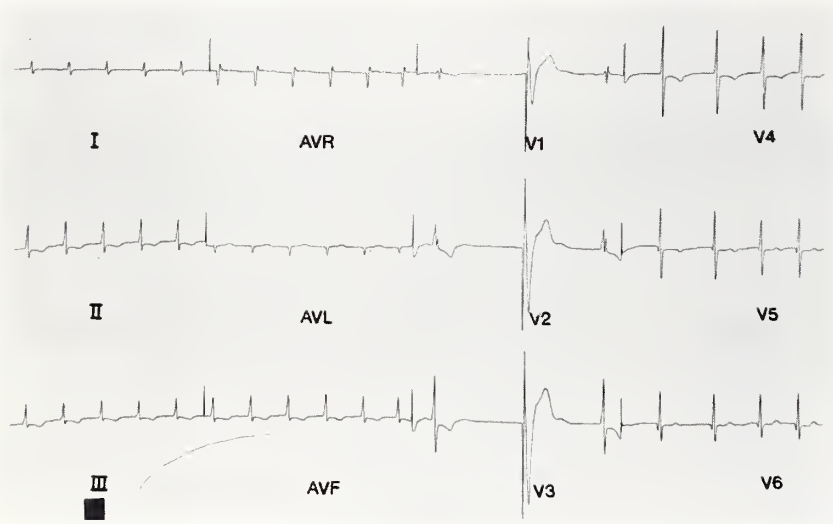
Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

400440

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a 51-year-old woman who had had open heart surgery in 1971. She did well until 1984, when she developed progressively worsening dyspnea on exertion. Now this dyspnea had worsened to the point where she could not walk one block or climb a few stairs without stopping to catch her breath. The patient denied orthopnea, paroxysmal nocturnal dyspnea, or chest pain. She thought she had palpitations or some rapid heart action during her dyspneic spells. Past medical history was important for rheumatic heart disease. Her physical examination showed a blood pressure of 120/80mmHg. Neck veins had prominent V waves. The lungs contained bilateral basilar crepitant rales. The cardiac exam had an increased first heart sound (S_1) with a loud pulmonary closure of the second sound (S_2). There was a left sternal border active cardiac impulse with a grade 4/6 pansystolic murmur in this area. At the apex, a soft opening snap and grade 3/4 diastolic rumble could be auscultated. After a procedure, a twelve lead ECG was recorded during palpitations.

Questions:

1. **The twelve lead ECG shows:**
   a. Paroxysmal supraventricular tachycardia
   b. A demand pacemaker beat.
   c. Atrial fibrillation.
   d. Idioventricular escape beat.
   e. Complete right bundle branch block.

2. **Management of this patient could include:**
   a. Cardiac catheterization.
   b. Repeat open heart surgery.
   c. Use of digoxin.
   d. ECG arrhythmia monitoring.
   e. All of the above.

(Continued on page 129)

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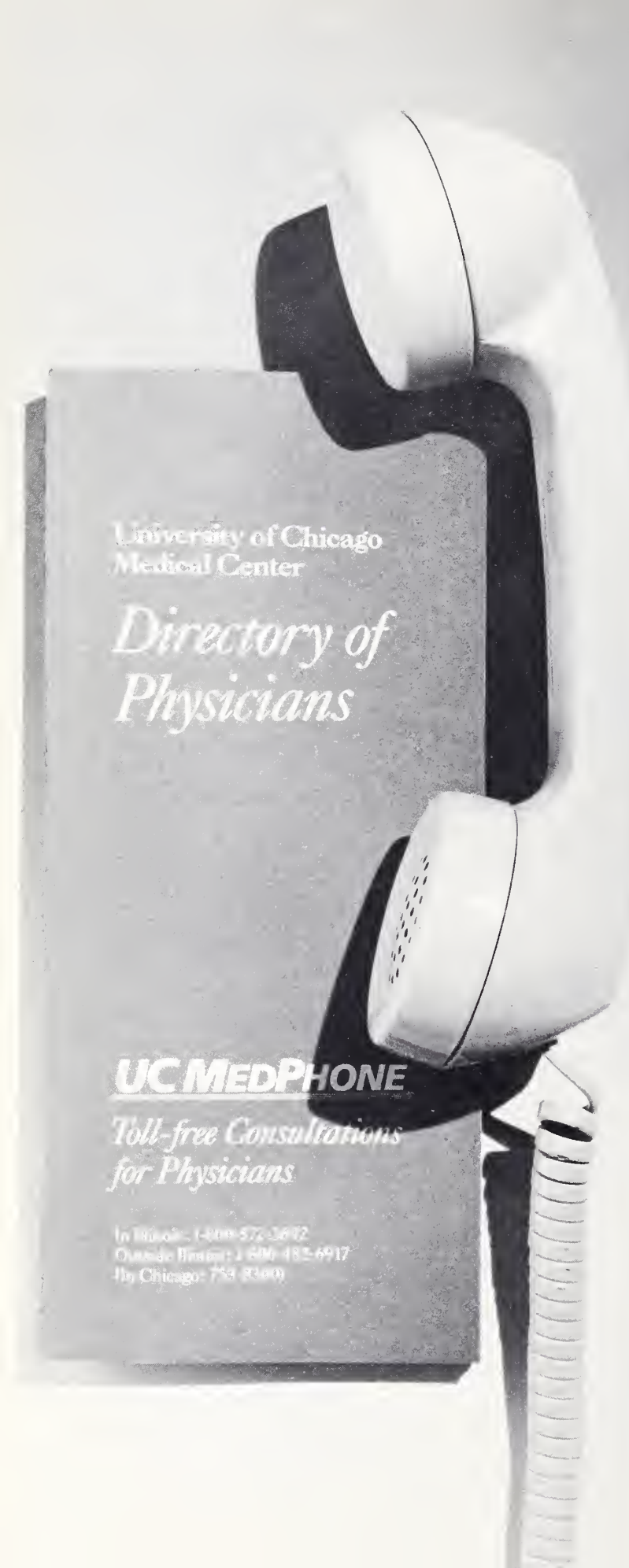
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OBITUARIES

***Barasch, Clarence J.,** Chicago, died December 24, 1985 at the age of 70. Dr. Barasch was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

***Daudish, Stanislaw,** Lyons, died December 23, 1985 at the age of 62. Dr. Daudish was a 1956 graduate of the Medizinische Fakultat der Rheinischen Friedrich-Wilhelms-Universitat, Bonn, Nordrhein-Westfalen, Germany.

****Dvorak, Vaclav G.,** Berwyn, died December 10, 1985 at the age of 85. Dr. Dvorak was a 1929 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Falk, Nathan,** Chicago, died December 15, 1985 at the age of 77. Dr. Falk was a 1935 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Glaser, George F.,** Chicago, died December 28, 1985 at the age of 92. Dr. Glaser was a 1921 graduate of Medizinische Fakultat der Martin-Luther Universitat, Halle, Germany.

****Langberg, Joseph,** Ciudad Satelite, Mexico, died June 26, 1985 at the age of 86. Dr. Langberg was a 1924 graduate of the Fak der, Universitat Wien, Wien, Austria.

****Malloy, Frank D.,** Palos Heights, died December 27, 1985 at the age of 83. Dr. Malloy was a 1927 graduate of Northwestern University Medical School, Chicago.

***Mera, John J.,** Rockford, died December 26, 1985 at the age of 65. Dr. Mera was a 1948 graduate of the University of Health Sciences/Chicago Medical School.

***Molina, Francisco A.,** Chicago, died December 25, 1985 at the age of 65. Dr. Molina was a 1947 graduate of the Facultad de Medicina de la Universidad de la Habana, La Habana, Cuba.

***Osland, Richard D.,** Belleville, died December 26, 1985 at the age of 62. Dr. Osland was a 1951 graduate of the University of Illinois College of Medicine, Chicago.

***Saltman, Simon Y.,** Napa, California, died December 20, 1985 at the age of 84. Dr. Saltman was a 1927 graduate of Northwestern University Medical School, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Two ISMS Past Presidents, Dr. J. Ernest Breed and Dr. H. Close Hesseltine

Two ISMS past presidents, who continued their active support of the Society long after retirement, died in December.

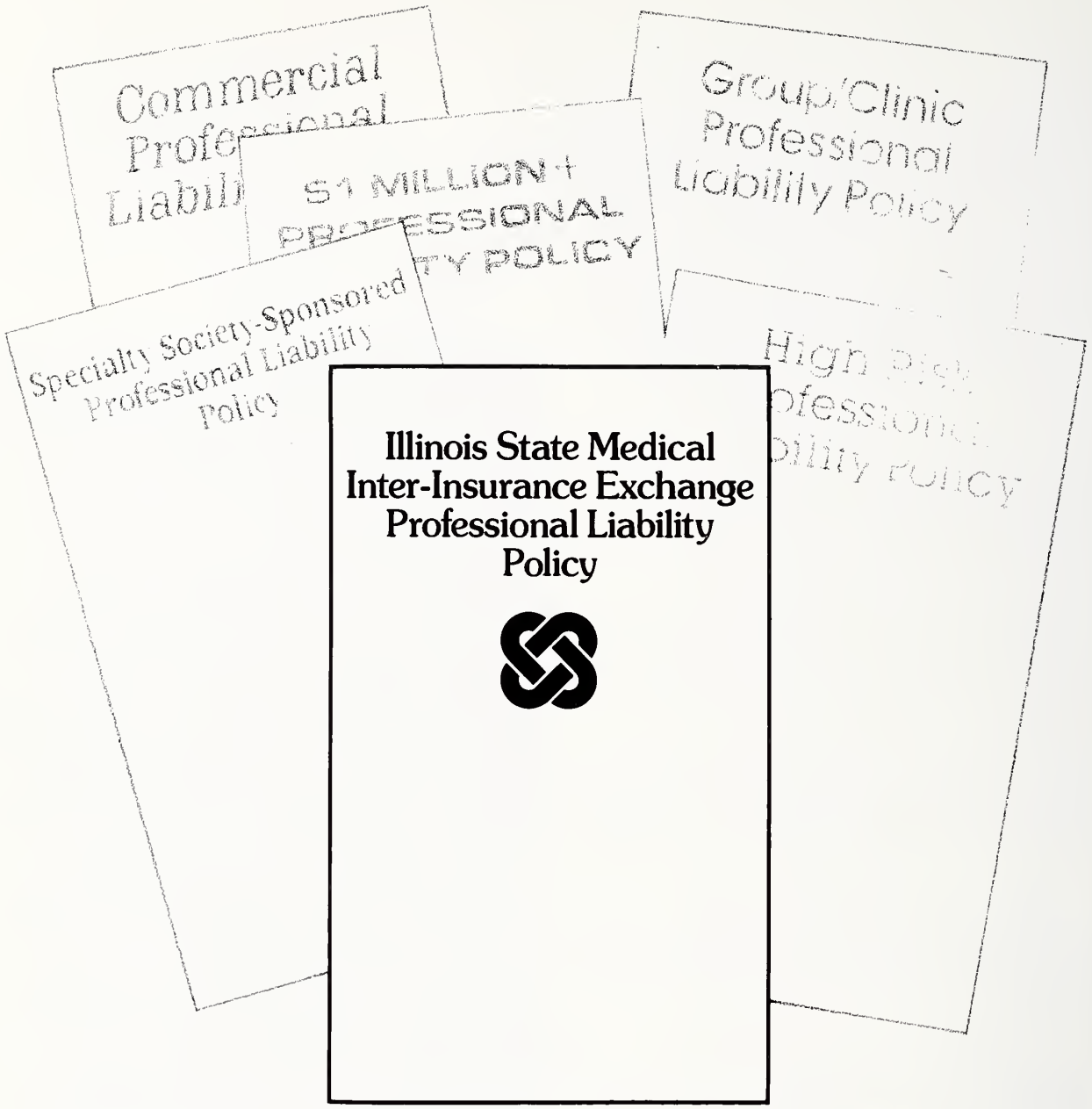
Dr. J. Ernest Breed, a Wilmette resident, died December 11 at the age of 83. The 1971 president of ISMS, he was an ISMS trustee for nine years.

Dr. Breed was an associate in radiology at Northwestern University Medical School for 20 years. He was a prolific author of clinical material and created seven educational films on radium therapy.

Dr. Breed had a particular commitment to legislative activity and medical education. He was the first secretary of the Illinois State Medical Society Political Action Committee and helped to establish the Illinois Council on Continuing Medical Education. A 1928 graduate of the Northwestern University Medical School, Dr. Breed practiced radiology until his retirement in 1980 at the age of 78.

H. Close Hesseltine, M.D., died December 13 at the age of 84. Dr. Hesseltine, an obstetrician and gynecologist, was the 1960 president of ISMS. He was chairman of the ISMS Council from 1956-58, a position which would now be termed chairman of the Board of Trustees. He also served as president of the Chicago Medical Society's Jackson Park Branch (1945) and the Chicago Gynecological Society (1958). He was active in his specialty as an associate examiner for the American Board of Obstetrics and Gynecology for 20 years.

At retirement, Dr. Hesseltine was named a Mary Campau Ryerson Professor Emeritus at the University of Chicago Hospitals and a professor emeritus at Rush-Presbyterian-St. Luke's Medical Center. A native of Promise City, Iowa, Dr. Hesseltine graduated from the University of Iowa College of Medicine in 1925 and returned to his home state after retirement.



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PRN
PHYSICIAN RESOURCE NETWORK™

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies.

From the Department of Alcoholism and Substance Abuse

Mandatory Use of New Triplicate Prescription Forms Begins March 1, 1986

The deadline to obtain the new Illinois triplicate prescription forms from the Department of Alcoholism and Substance Abuse (DASA) is fast approaching. On March 1, 1986, the new triplicate prescription forms will be mandatory for use in prescribing Schedule II designated product prescription drugs.

Also, on March 1, 1986, the previously issued "green" triplicate forms will become null and void and will no longer be accepted by Illinois pharmacies.

If you have received your application form in the mail, fill it out and return it to the Springfield DASA office *as soon as possible.* Persons who have not yet received an application form to participate in the new triplicate prescription program, should contact DASA's Triplicate Prescription Control Section in Chicago, 312-917-6387, or in Springfield, 217-782-1305, to obtain the necessary forms.

(Source: Correspondence from Manager, Triplicate Prescription Control Section)

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

March 10	Copley Immediate Care Center	*Aurora*
March 4-6, 10, 11	Franklin Park Public Library	*Franklin Park*
March 9-13	Victory Memorial Hospital	*Waukegan*
May 19-23	Family Health Center	*Round Lake Beach*
November 3-7	Condell Memorial Hospital	*Libertyville*

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Chicago Hilton and Towers
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FOR INFORMATION, CONTACT
THE EDUCATION DIVISION
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AT 312-670-2550.



MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The Framingham Study evaluated the use of estrogen in postmenopausal women. Estrogen and smoking increased the risk factor for cardiovascular morbidity by 50% and showed a two-fold increased risk for cerebrovascular disease. Among non-smokers, estrogen use was associated only with an increased incidence for strokes. No estrogen benefits were reported in the study group. (Wilson, P., *et al: N Engl J Med* 313:17, 1038-43, 1985.

Recent cerebrovascular accident cases due to atherosclerotic lesions at the middle meningeal artery or the internal carotid artery were divided into two groups for treatment. Approximately half the group were treated by conservative therapy and the other group had surgical by-pass from the superficial femoral artery to the middle meningeal artery. These patients were then followed for an average of 55.8 months. The 30 day surgical mortality was 2.5% compared to the mortality of 0.6% for the conservatively treated group. The study indicated that this surgical procedure was not of value in patients with atherosclerotic arterial disease in the carotid and middle meningeal arteries. (The Extra-Cranial to Intra-Cranial ByPass Study Group: *N Engl J Med* 313-19, 1191-1200, 1985)

The use of the automatic injector or intramuscular syringe administration of 400mg lidocaine into a patient's deltoid muscle upon suspicion of an acute myocardial infarction was shown to markedly reduce the incidence of primary ventricular fibrillation. Side effects were rare and did not contribute to mortality. Intramuscular lidocaine by a paramedic, another person, or the patient himself when acute myocardial infarction is suspected outside the hospital, may be life-saving. (Koster, R., Dunning, A.: *N Engl J Med* 313:18, 1105-10, 1985)

A deficient intake of dietary fiber rather than genetic factors may be responsible for phleboliths, especially diverticular disease and hiatus hernia. All three conditions were equally present in white and black Americans. The incidence in Africa and other third world countries was markedly less, which may be due to environmental factors. (Burkitt, D. *et al: Lancet* 8460:2, 880-1, 1985)

A randomized, double blind, placebo-controlled, crossover study on oral calcium in patients with mild to moderate hypertension was evaluated in 48 hypertensive and 32 normotensive patients. The oral administration of 1000mg/d of calcium for 8 weeks, in either carbonate, citrate, or dairy products, reduced the supine systolic by 3.8mmHg, and the diastolic by 2.3mmHg. The standing systolic was reduced by 5.6mmHg, and the diastolic also by 2.3 mmHg. No significant adverse effects were noted in either the control or hypertensive groups. (McCarron, D., Morris, C.: *Ann Int Med* 103:6, 825-31, 1985)

American trypanosomiasis infects approximately 10-12 million Latin Americans and is endemic from Mexico to Southern Argentina. It is not a reportable disease in the United States. Immigrants from these endemic areas may have a chronic form of disease with cardiac arrhythmias, cardiomyopathy, or megadisease-esophygeal or colonic dilatations and dysfunctions. Cerebrovascular accidents are frequent with patients with severe chagasic cardiomyopathy and mural thrombi. No present medicinal preparations are commercially available for the treatment of this chronic disease. (Kirchhoff, L., Neva, F.: *JAMA* 254:21, 3058-60, 1985)

Acute myocardial infarctions exhibited a circadian rhythm with a three-fold increase in the frequency of onset at the peak of 9:00 a.m., compared with the trough at 11:00 p.m. This circadian rhythm was not present in patients on beta-adrenergic blocking agents before myocardial infarction. (Muller, J., *et al.: N Engl J Med.* 313:21, 1315-22, 1985)

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- Connecticut General Life Insurance Company
- Equitable Life Assurance Society of the U.S.
- The Great-West Life Insurance Company
- Gulf Group Services
- The Hartford Insurance Group
- Home Life Insurance Company
- John Hancock Mutual Life Insurance Company
- Liberty Life Assurance Company
- Lincoln National Life Insurance Company
- Massachusetts Mutual Life Insurance Company
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- Pacific Mutual Life Insurance Company
- Philadelphia American Life Insurance Company
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- Prudential Insurance Company
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- The Travelers Insurance Company
- Unionmutual Stock Life Insurance Company

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Colwell Systems	1-800-252-6960
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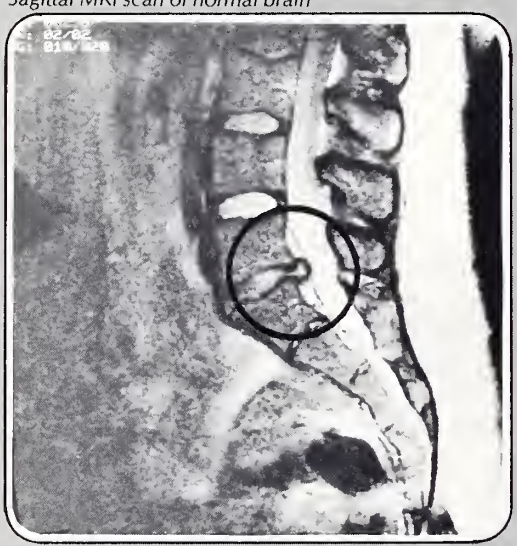
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MARK GREENBERG, M.D.
Diplomate American Board of Radiology

The Illinois State Medical Society

Who We Are And What We Do

A Special IMJ Section on Membership

Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602 · 312-782-1654 · 1-800-782-ISMS

Staying Strong and Getting Stronger



This month, we have a special issue on membership. The geodesic sphere reproduced on the cover is intended to show how individual members determine the strength of the whole.

The geodesic dome was invented by an architect, R. Buckminster Fuller. It is much stronger than most structures. The structural strength of each dome is much greater than the sum of its individual parts, just as the strength of ISMS as an organization is much greater than the sum of its individual members.

The concept of the geodesic dome uses one of the strongest and oldest geometric figures—the triangle. A series of equilateral triangles are combined to resemble the shape of the earth. Our professional affinity is similarly rooted in antiquity, evolving from a shared heritage dating to Hippocrates.

This special membership issue is designed to answer one question: What am I getting for my dues dollar?

ISMS members pay $253 for annual dues. County society dues range from very few dollars to $300. AMA dues are $375. The combined total for Illinois physicians is determined by county of membership. Whatever the total, Illinois physicians receive a terrific return on their dues investment. To obtain elsewhere the services and benefits offered by organized medicine, the individual physician would have to pay far more.

If there were no county, state and national professional associations, they would be sorely missed and hastily replaced. I think that most of us know that, on some conscious or subconscious level. Just the same, I'd like to ask each member to spend some time with this issue. After you've read it, please share it with a non-member colleague and encourage him or her to join our ranks. Most Illinois physicians have already chosen ISMS. Each new member enhances our credibility—with the legislature, with the media and with the public. There is strength in numbers.

There are two response cards inside the back cover. One is designed for members who seek more information on how to participate more fully. The second is for a non-member who is ready to take the first step toward joining. I'm asking each of you to make use of both of these cards.

Motivating members and recruiting new ones—that's what this issue is all about. ISMS is working hard at staying strong and getting stronger.

Morgan M. Meyer

Morgan M. Meyer, M.D.
ISMS President

ISMS and Medical Practice

152 Products of Professional Partnership

One of the purposes of this special issue on membership is to bring home the fact that the practice of medicine in Illinois would be entirely different without ISMS. Dozens of professional and public health issues have been confronted and resolved through the earnest effort of our members working through their professional association. The list below includes some of the more tangible benefits ISMS has brought to medical practice in Illinois over the past few years.

Child and Maternal Health

1 Worked with the Illinois Commission on Children to improve the state's health services to adolescents.

2 Made available a brochure on child car seats for physicians to distribute to their patients with small children.

3 Sponsored physician education programs on child abuse with the Department of Children and Family Services and the AMA.

4 Participated in deliberations of the Illinois Department of Public Health (IDPH) Perinatal Policy Advisory Committee to create long-term state policy for medical services to disabled newborns.

5 Under a contract with IDPH, evaluated maternal deaths for statistical purposes.

Contracting

6 Established an office of contractual services to provide members with summaries in layman's language of the major terms and conditions of proposed Health Maintenance Organization (HMO), Individual Practice Association (IPA) and Preferred Provider Organization (PPO) contracts. To date, the office has completed over 800 individual summary responses concerning more than 80 alternative delivery systems.

7 Conducted seminars on alternative delivery systems and physician contracting issues for county medical societies and hospital medical staffs. Published a brochure for physicians on the major contracting issues.

8 Sponsored sessions on contracting with alternative delivery systems and IPA case studies at the ISMS All Member Conference.

Correctional Health Care

9 Created and distributed to all Illinois county sheriffs a "Handbook for Correctional Officers: Inmates with Alcohol and Drug Problems," under a state grant.

10 Conducted seminars for health personnel of the Department of Corrections to upgrade their knowledge in specific disease areas.

11 Provided medical and administrative consultation to county jails, under a federal grant, on developing and improving health services to inmates.

12 Surveyed several Illinois county jails to determine their compliance with national health care standards for correctional facilities.

Discipline

13 Through component societies, hospital medical staffs, district committees and the Exchange, performed peer review monitoring to improve the quality of medical care in Illinois.

14 Helped to create a Governor's Task Force on Medical Discipline to examine the current disciplinary process and to identify a physician to serve as medical coordinator for the Illinois Medical Disciplinary Board.

15 Created a booklet on the mandatory reporting amendments to the Medical Practice Act, in cooperation with the Chicago Medical Society, Chicago Hospital Council and the Illinois Hospital Association.

16 Supported increased funding of the state's Medical Disciplinary Board through licensure fees in order to empower that Board to monitor and improve the quality of medical care in Illinois. Monitored the twice-monthly meetings of the Medical Disciplinary Board in their review of complaints and investigations regarding physicians.

Education

17 Sponsored a medical student loan program providing up to $2,500 per year to eligible Illinois residents attending an Illinois medical school. Coordinated fund raising raffle for scholarship monies. ($100,000 has been approved for distribution in 1985-86.)

18 Co-sponsored with the Illinois Agricultural Association a second student loan program for students attending the University of Illinois College of Medicine.

19 Contributed more than $50,000 to the American Medical Association's Education and Research Foundation to further the purposes of medical education. (An annual ISMS contribution is accompanied by thousands of dollars raised by the ISMS Auxiliary to assist Illinois medical schools and their students.)

20 Supported activities to help Illinois continuing medical education sponsors develop and improve their educational programming.

21 Administered an intrastate accreditation program, which approved and monitored over 80 local continuing medical education programs within Illinois at community hospitals and county medical societies.

Health Planning

22 Participated in the Illinois Health Care Cost Containment Council, which is charged by the legislature with making recommendations about cost containment measures.

23 Participated in the state health planning process.

24 Participated in ongoing development of policy issues, statements and implementation strategies for the AMA's Health Policy Agenda

25 Conducted a study and published a paper on the status of free-standing emergency centers in Illinois.

26 Participated and monitored the deliberations of the Illinois Department of Public Health Medical Determinations Board as it provided medical input into the policy and program decisions of the state health department.

27 Participated in development and design of Illinois and Chicago laws to designate and regulate trauma centers.

Hospital Medical Staffs

28 Worked to see that due process rights for medical staff members were included in hospital licensing requirements.

29 Created a Section on Hospital Medical Staffs with voting representation in the ISMS House of Delegates.

30 Alerted medical staffs to new Joint Commission on Accreditation of Hospitals standards enhancing medical staff participation in decision-making within multi-hospital systems and corporately restructured hospitals.

31 Supported legislation to provide immunity from civil liability for medical staff members and hospital personnel involved in peer review activities.

32 Provided programs on medical staff competency, organization and joint ventures at the ISMS All-Member Conference.

33 Proposed new Hospital Licensing Act rules requiring due process provisions in medical staff bylaws.

34 Monitored quarterly meetings of the Hospital Licensing Board, which reviews and creates new rules on hospital and medical staff services, structure and composition.

35 Created and distributed "Due Process Guidelines for Physicians," to assist medical staffs in designing appropriate protections in their bylaws.

36 Developed, published and disseminated the ISMS "Guide to Hospital Medical Staff Bylaws," to assist medical staffs in drafting these key documents.

37 Created "Legal Considerations of Medical Staff Bylaws," to help medical staffs understand the ramifications of various bylaws provisions.

Impairment

38 Hosted the first Midwest Conference on the Impaired Physician, which brought together impaired physician committees from six midwest state medical societies to exchange information.

39 Conducted training programs for physicians, residents and students who volunteer to intervene and monitor the recovery of impaired physicians.

40 Created 12 intervention teams, composed of 50 physicians and residents from around the state, to assist impaired physicians.

41 Created and distributed to all hospitals "Guidelines for Hospital Committees to Assist Impaired Physicians," to encourage the formation of such groups at every Illinois facility.

Legislation

42 Helped enact legislation to require use of seat belts in passenger motor vehicles.

43 Blocked legislation to provide for the licensure and independent practice of acupuncturists.

44 Supported and helped pass legislation to require physical fitness centers to have a person certified in cardio-pulmonary resuscitation on premises at all times.

45 Blocked legislation to license electrologists.

46 Passed legislation to streamline the addition and deletion of drugs to the Department of Public Aid Drug Manual.

47 Helped prevent enactment of legislation to license paramedics. (Paramedics are currently certified.)

48 Defeated legislation to require the execution of consent forms specific to surgical procedures for breast cancer.

49 Defeated legislation that would have prohibited hospital based radiologists from charging fees for the interpretation of x-rays.

50 Blocked legislation to license persons wanting to engage in the practice of naprapathy.

51 Defeated legislation to license the independent practice of social workers.

52 Opposed legislation that would have removed penalties associated with non-compliance with school health mandates.

53 Opposed legislation to excuse 11th and 12th grade students from physical education classes.

54 Defeated a legislative proposal to impose a $1,000 fine on physicians for failure to sign a death certificate within three days.

55 Imposed interest penalties on municipalities which fail to pay in a timely fashion for the medical expenses of policemen and firemen injured in the line of duty.

56 Successfully prevented criminal penalties in cases where child abuse is not reported by a physician.

57 Defeated legislation providing for separate licensure for nurse anesthesists.

58 Successfully opposed legislation to require medical malpractice insurers to file unnecessary reports.

59 Opposed legislation allowing for punitive damages against insurance companies for supposed unfair claims practices.

60 Successfully opposed legislation to allow outside access to confidential peer review data.

61 Defeated legislation providing for pre-judgment interest awards.

62 Successfully defended the provisions of the Medical Studies Act which provide for the protection of hospital peer review and ethics committees' records.

63 Successfully supported several proposals to improve medical discipline.

64 Supported legislation creating an Addiction Research Institute at the University of Illinois.

65 Opposed legislation that would have allowed clinical psychologists to independently diagnose and treat mental, emotional and behavioral disorders.

66 Successfully changed onerous provisions of mandatory continuing medical education.

67 Prevented repeal of the law requiring that students entering 5th and 9th grades must submit proof of receiving health exams.

68 Successfully amended provisions of the Athletic Trainer's Practice Act to require physician supervision.

69 Successfully opposed legislation requiring physicians to report incidents of head injuries to the Department of Rehabilitative Services.

70 Prevented enactment of bills that would have legislated medical school curricula.

71 Opposed legislation which would have banned physicians from recommending a pharmacy for the filling of prescriptions.

72 Successfully supported legislation to exempt records of the Organ Transplant Board from the Freedom Of Information Act.

73 Opposed legislation that would have imposed a tax on the performance of physician services.

74 Opposed legislation allowing for the imposition of taxes on insurance companies by political subdivisions.

75 Supported legislation that now includes Health Maintenance Organizations under the protections afforded by the Medical Studies Act.

76 Successfully supported legislation to increase the penalties for persons who practice medicine without a license or fraudulently obtain medical licenses.

77 Successfully defeated legislation reducing the length of medical education required to qualify for licensure.

78 Successfully supported legislation allowing directors of hospitals to have a professional interest in the institution.

79 Opposed several legislative attempts that would have compromised the confidentiality of medical records.

80 Successfully opposed an attempt to permit nurses to make medical diagnoses and prescribe therapeutic measures.

81 Successfully amended the Living Will Act to remove criminal penalties.

82 Successfully supported legislation to improve safety precautions at boxing matches.

83 Successfully amended the Hospital Revenue Act to provide for a competitive rather than regulatory approach to hospital cost containment.

84 Successfully supported legislation to promote organ donations.

Loss Prevention

85 Provided educational programs for Illinois physicians on techniques to reduce the possibility of malpractice litigation. Over 4,000 Illinois physicians have participated to date.

86 Published *Antidote*, a bimonthly newsletter which employs medico-legal case studies to illustrate loss prevention principles.

87 Developed the Physician Support Group for physicians who are experiencing psychological stress as a result of malpractice litigation.

Media Relations

88 Responded to over 300 media requests.

89 Promoted media visibility for the ISMS President's Tour to county medical societies, the Annual Meeting and the All-Member Conference.

90 Mounted a statewide media relations campaign on the need for medical malpractice reform—including editorial visits, broadcast interviews and news conferences.

91 Sponsored a medical malpractice briefing session for hospital public relations professionals.

Medical-Legal Activities

92 The Illinois State Medical Society monitors medical-legal affairs in order to respond on behalf of its members to events affecting the profession as a whole. Legal actions on the following issues were monitored over the past two years. (Instances where ISMS entered an *amicus* brief to support medicine's position are identified with an asterisk.)

—Venue*
—Community standard rule or locality rule*
—Statute of limitations
—Privacy of physician's name
—Pre-judgment interest*
—Constitutionality of professional liability legislation*
—Foreseeability of harm
—Corporate practice of medicine
—Mandatory levels of malpractice insurance
—Confidentiality of the medical studies act

93 Created, in cooperation with the Illinois State Bar Association, "Guidelines for Attorney-Physician Relationships," which suggests how the two professions should interact under various situations.

94 Restructured the ISMS Impartial Medical Testimony Program, soliciting physicians to serve as impartial evaluators for Circuit Courts and the Industrial Commission.

95 Developed and distributed "A Physician's Guide to the Illinois Living Will Act," to help physicians understand their responsibilities under this law.

96 Revised and simplified the ISMS "Guidelines for Writing Do Not Resuscitate Orders."

Member Communications

97 Produced a variety of membership publications—including *Action Report* and the *Illinois Medical Journal*—to keep physicians up-to-date on socioeconomic and clinical developments in Illinois medicine.

98 Published the *On the Legislative Scene* newsletter while the Illinois General Assembly was in session to keep physicians abreast of what was happening in the state Capitol.

99 Developed videotapes, slide shows and other audiovisual resources to promote member interest in and patient awareness of medical malpractice reform.

100 Presented on-camera practice sessions for ISMS members serving as public spokespersons on medical issues.

Membership Services

101 Sponsored personal group insurance protection programs for physicians, including life insurance, major medical, Medicare supplemental, hospital indemnity, and accidental death and dismemberment coverage.

102 Sponsored several other practice-related group insurance protection plans, including disability income, practice overhead, and workers' compensation coverage.

103 Offered personal financial planning services to physicians, including a retirement program and estate planning.

104 Provided needed financial support to physicians and their families through the Illinois State Medical Benevolence Fund.

105 Continued to offer as a membership benefit Avis-Rent-A Car's Worldwide Discount Program to physicians.

106 Sponsored a series of travel programs that offered medical seminars featuring leaders in the field of medicine throughout the world.

107 Offered members the opportunity to make personal travel arrangements on a special priority basis and to obtain hotel discounts.

Physician Distribution

108 Published "A Little Luck is Not Enough," a handbook to assist rural communities in locating and recruiting physicians.

109 Completed a research study on the factors affecting ultimate practice location choices of Illinois medical graduates.

110 Worked with the Illinois Department of Public Health to place National Health Service Corps graduates in appropriate locations.

111 Administered the physician recruitment program, which works to match physicians with communities in need of medical services.

Professional Liability

112 Authored and vigorously supported comprehensive medical malpractice reform, through the Professional Liability Initiative, which passed in the 1985 legislative session.

113 Filed an *amicus curiae* brief to protect the new malpractice legislation against court challenge.

114 Established and maintain the Illinois State Medical Inter-Insurance Exchange, the only physician owned and operated malpractice insurance carrier in Illinois.

Public Education

115 Distributed television public service announcements on the benefits of quitting smoking.

116 Published a patient oriented monthly health commentary column for Illinois' weekly newspapers.

117 Issued news releases, letters to the editor and opinion pieces on health-related topics, such as seat belts, teen suicide and treatment of impaired physicians.

118 Sponsored a booth at the Illinois State Fair to provide public information on hypertension, skin problems, prescription drug use and other medical topics.

119 Contributed to the ongoing activities of the Illinois Interagency Council on Smoking and Disease

Public Health

120 Created and produced an Emergency Medical Information card for distribution at Drivers License Application Centers.

121 Co-sponsored a program under a federal grant, with the Illinois Migrant Council, to bring migrants into mainstream community health services.

122 Monitored the deliberations of the Ambulatory Surgical Treatment Center Advisory Board.

123 Helped to develop recommendations on HTLV-III antibody testing, which were adopted by the state health department.

124 Reviewed new rules for TB screening in Illinois.

125 Helped to develop rules for administering the new Illinois Experimental Organ Transplant Procedures Act and Board.

126 Created a booklet, "Guidelines for the Provision of Medical Care at Large-Scale Events," to meet the needs of those planning medical services at state fairs, large sporting events and other activities where over 5,000 people would be present.

127 Cooperated with the American Cancer Society, Illinois Radiology Society, Chicago Medical Society and Illinois Society of Pathologists in creating a mammography screening project aimed at female members of physician families.

128 Participated in the development of objectives for the new Health and Hazardous Substances Registry.

129 Examined and endorsed the concept of a state cancer registry.

130 Examined and supported the interim IDPH guidelines dealing with school children with AIDS.

131 Created an ad hoc Committee on AIDS to monitor clinical, legal, ethical and social issues involving a physician's treatment of an AIDS patient.

Reimbursement

132 Assisted members with difficulties in the claim processing, policy, procedural and/or audit techniques of governmental and private third party payors.

133 Successfully pressed for increases in physician reimbursement under the Illinois Department of Public Aid (IDPA) medical assistance program. In 1985, physicians received a 5% increase in IDPA reimbursements.

134 Worked directly with Medicare, Medicaid and private insurers to evaluate rules and regulations for the various reimbursement programs.

135 Worked with the Illinois Department of Public Aid to evaluate new drug products proposed for reimbursement eligibility under Medicaid.

136 Brought physician concerns about Medicare program issues to the attention of both the Illinois Professional Review Organization and Health Care Financing Administration.

Sports Medicine

137 Wrote and distributed to high school and college coaches and trainers the *A.I.D.* newsletter on preventing and handling sports related injuries.

138 Sponsored the ISMS Physician Games, an event which brought together physician families to compete in sporting events, clinical programs and social activities.

139 Presented six Team Physician Awards to physicians who have given over ten years of volunteer services to the young athletes of their communities.

140 Offered the ISMS Sports Medicine Committee as medical consultant to the Prairie State Games for Illinois athletes.

141 Created and disseminated "The Female Athlete: A Look at the Facts," a brochure debunking myths about the medical limitations of women competing in sports.

Spouses

142 Supported the ISMS Auxiliary, which works to enhance and implement ISMS initiatives, to promote the profession and to benefit the public health.

Students and Physicians-In-Training

143 Established and supported the Medical Student Section (MSS) and Resident Physicians Section (RPS) as statewide representative bodies for Illinois students and residents within organized medicine.

144 Provided a voice in organized medicine through delegate and alternate positions for the MSS and RPS in the ISMS House of Delegates and also a resident delegate position and student alternate delegate position on the ISMS Delegation to the AMA.

145 Publish the "MSS Bulletin" and the "RPS Rounds."

146 Established and implemented the Illinois Medical Education and Community Orientation (MECO) Program.

147 Sponsored conference on the "Hazards of Medical School and the Potential for Impairment," and co-sponsored conferences on resident physician stress.

Substance Abuse

148 Helped state agencies to implement the PADS (Prescription Abuse Data Synthesis) system, designed to prevent misuse of prescription drug products.

149 Created, through a state grant, "The Physician's Role in Recognizing Substance Abuse," a self-directed learning package and audiotape to help physicians identify and deal with substance abusing patients.

150 Conducted, through a state grant, a seminar titled "A Substance Abuse Primer for Physicians" at six sites around Illinois.

151 Worked closely with the Department of Alcoholism and Substance Abuse in redesigning the form and rules of the Triplicate Prescription Program.

152 Proposed and assisted in the development of a Medical Advisory Committee for the Department of Alcoholism and Substance Abuse.

A Voice and a Forum

Recent developments in health care delivery have led to an increased focus on the hospital medical staff. New elements such as joint ventures and DRGs, and continuing concern in such areas as peer review and liability, have significantly affected the structure and management of hospitals. These medical staff issues have drawn increased attention from organized medicine.

Medical staff issues of growing import have included insufficient input into hospital planning and decision-making, contracting arrangements, cost containment strategies potentially affecting quality care, and the role of non-physician providers.

Although ISMS had dealt with medical staff issues in the past, the volume and weight of attendant matters accelerated significantly in the eighties. When the AMA created a Hospital Medical Staff Section, ISMS offered staff support to those physicians representing their medical staffs in the Section. Eventually, the ISMS House of Delegates created a Committee on Hospital Medical Staffs reporting directly to the ISMS Board of Trustees. Then, at the 1985 Annual Meeting, the House of Delegates created its own Hospital Medical Staff Section (HMSS) with its own voting delegate. The ISMS/HMSS now provides a medical staff perspective to the policy-making House of Delegates. Additionally, it provides a forum for hospital medical staff representatives to discuss common issues and concerns, and to increase awareness of and communication about medical staff issues.

Leadership of the HMSS is through an elected 10-member governing council chaired by Raymond A. Dieter, Jr., M.D. All Illinois hospital medical staffs are eligible to select a representative to the ISMS HMSS. The representative must (1) have active clinical privileges on the staff, (2) be an ISMS member, and (3) be elected by the hospital medical staff. Representatives certified in the AMA/HMSS are automatically certified in the ISMS/HMSS, unless changed by the medical staff. There are three meetings per year of the Section. Two are in caucus form during the AMA/HMSS Annual (June) and Interim (December) meetings, and the third is the annual business meeting. The first annual business meeting will be Saturday, March 1, 1986 in Chicago. The meeting precedes the Annual ISMS meeting (April 4-6, 1986).

According to Dr. Dieter, "Establishment of the HMSS demonstrates ISMS commitment to its mission to provide representation of the medical profession. The Section's effectiveness depends to a large degree on the involvement of Illinois medical staffs in selecting representatives and sending them to the meetings. It is an ideal opportunity to participate, contribute, and have a voice in the state society and the future of medicine."

How the System Works

The Nuts and Bolts of It

The accomplishments of any professional association are rooted in the energy of its members. Individuals define the effectiveness of the association. Individual decisions to pay dues, to volunteer time, to offer expertise or to voice an opinion are the driving forces behind a successful association.

Just as the success of a democracy is determined by the energy and expertise of its citizens, so the value of any group is only as good as its members are willing to make it.

Organized medicine is structured in a system analagous to that of the U.S. government. Local governments/county medical societies provide a forum for grassroots participation. State governments/state medical societies deal with issues of wider geographic impact, often germinated by controversy at the local level. The federal government/American Medical Association resolves those issues requiring a global perspective.

The voluntary association is a training ground for the democratic process. It can provide a means to settle issues without passing another law or filing another lawsuit. And while the decisions of a voluntary association are not binding on legislative bodies or policy-makers, they do have influence. The voice of an organized professional group is the articulation of a politically conscious constituency. At the local, state or national level, this will carry some weight.

The policy-making structure of organized medicine is designed to deal with the concerns and suggestions of members. It illustrates a classic point: by working through the system, one person can make a difference.

Individual Provides the Spark

Many actions begin when a physician voices an opinion or an idea at a meeting of his or her county medical society. Smaller county medical societies may be able to act upon it at that very meeting. A larger county society may form a study group. If the committee favors the proposal, it is likely to be supported by the society's ruling body or adopted at a general membership meeting. Deliberations on a local issue may end there, and the solution implemented by county society officers or staff.

If the proposal has impact beyond the county of origin, the county medical society may decide to ask the Illinois State Medical Society to take action. The matter is referred to a resolutions committee, as the request for action usually takes the form of a "resolution" drafted for submission to the state medical society policy-making body—the ISMS House of Delegates.

Action at the State Level

The House meets annually—semi-annually if issues warrant an interim meeting. It is comprised of delegations from each of the Society's component county medical societies. The Society's officers and members of its Board of Trustees also have a vote. One vote each is also afforded to the ISMS Hospital Medical Staff, Resident Physician, and Medical Student sections. Other organizations, such as state medical specialty societies, may be represented in discussions without a vote.

Meetings of the ISMS House of Delegates usually are held over two or three days to allow sufficient attention to the business before it. To facilitate an issue's consideration, the House assigns each resolution to one of several "reference committees" whose role is to listen, to debate and to make recommendations to the House regarding possible actions.

Any member of ISMS may attend and participate in debate before the reference committees. At conclusion, recommendations of the committee are embodied in reports made to the entire House. Committee reports and recommendations are presented for approval or debate by the entire House.

Every man owes part of his time and money to the business or industry in which he is engaged . . . no man has a moral right to withhold his support from an organization that is striving to improve conditions within his sphere.

—Theodore Roosevelt

When the House of Delegates addresses an issue, several things can happen. If an item is best addressed at the state level, the Society's Board of Trustees usually will be directed to take whatever action is necessary. If the matter needs more study, the Board may turn to an ISMS council or committee for advice. They will complete the research and report to the Board of Trustees. (*See inset*) The Board will submit attendant recommendations to the House at its next meeting in the form of an "unfinished business report."

Not all action ends with the ISMS House of Delegates. Often, a resolution will call upon ISMS to seek corresponding action by the AMA. In recent years, ISMS has successfully sought national concurrence on such issues as reimbursement nomenclature and designation of certain surgical procedures as reconstructive rather than cosmetic. In these instances, a resolution similar to that passed by the ISMS House was drafted for submission to the American Medical Association House of Delegates.

The National Forum

The state Society resolution is carried to the AMA House by the ISMS Delegation to the AMA, a group of 19 delegates and 19 alternates elected by the ISMS House. The delegation takes its direction from the ISMS House; its chairman is an ex-officio member of the ISMS Board of Trustees and provides liaison between the Board and the rest of the AMA Delegation.

The AMA House meets twice a year to set policy for the American Medical Association. Its structure is much the same as that of the ISMS body, but its concerns are larger in scope. As with ISMS, the AMA has a Board of Trustees that is responsible for carrying out House directives and a wide array of councils

ISMS Councils and Committees Complete Research and Formulate Solutions

Each year, over 300 physicians, residents and students volunteer their mornings, afternoons, evenings and weekends to serve on ISMS councils and committees. These study groups examine, develop and implement policies, programs and publications for Illinois physicians and their patients.

The ISMS Board of Trustees delegates the responsibility to determine how actions or policies of government, professional and private groups should be met. The cooperation and diligence of volunteer members enables the leadership to guide the Society with confidence, strength and success.

ISMS councils and committees are created to handle specific areas, such as sports medicine and worker's compensation, and general subject areas such as economics and medical-legal affairs. Members with expertise or interest in a particular sphere come together periodically to discuss items within their purview and recommend pertinent action to the ISMS Board.

This committee work also serves as fertile ground for the Society to identify and train its future leaders. Chairmen and members learn to work with ISMS staff in reviewing issues, designing alternatives and implementing directions of the Board and House of Delegates. Volunteers see and participate in the Society's efforts to protect, promote, and represent Illinois physicians.

Many of the benefits a physician receives from ISMS are not tangible. However, volunteers get a greater appreciation for the behind-the-scenes work necessary to pass legislation, develop publications and programs and convince others of organized medicine's positions. Another benefit is a sense of genuine satisfaction in making an impact in the public domain.

Committee work gives the individual member an opportunity to bring an issue or problem before the Society and have it successfully resolved. It also provides the forum to create and develop new ideas to benefit physicians and their patients using the ISMS resources and expertise.

Without participation, a member is only a spectator to the rapid changes in medicine. ISMS speaks for those who take the time to care about their profession by giving of themselves. Those who choose to participate have the satisfaction of seeing ISMS evolve to reflect, in some part, their image of medicine.

and committees which study issues.

The AMA House is made up of state delegations and specialty society delegates. There were 371 delegates and almost as large a contingent of alternate delegates at the December, 1985, interim meeting. Illinois has 19 of these—only two states, New York and California, have larger delegations. At the meeting itself, specialty society delegates from Illinois are also invited to join with the delegation in its deliberative meetings and on the floor of the House.

Illinois Delegates Working Through the System

The Illinois Delegation not only is one of the largest but also one of the most effective. Its effectiveness stems not only from its size, but also from the way it organizes itself, and the amount of hours it spends on its work.

Prior to each House meeting, the Delegation works in subcommittees to study and make recommendations on resolutions and reports. Immediately before the meeting, the Delegation meets for one full day, deliberating resolutions and reports, and deciding as a delegation, to support, oppose or amend the business before the House. A delegation member will be assigned to speak for or against resolutions and reports that the delegation feels strongly about.

The Politics of Persuasion

In addition to policy-making, the Delegation is an organizational and political force in the AMA House. Delegates and Alternate Delegates are assigned to get to know other state's delegates and specialty society delegates. When important votes are taken, the Illinois Delegation can influence the outcome of the vote through persuasion and continuing discussion.

In the last five years, the Illinois Delegation has made impressive election victories in the AMA House. Frank J. Jirka, Jr., M.D., of Barrington was elected AMA president. John Ring, M.D., of Mundelein was elected to the AMA Board of Trustees, and is up for re-election this year. Ron Davis, M.D., of Chicago was elected to the first resident spot on the AMA Board of Trustees. Joseph Skom, M.D., Chicago, was re-elected to the Council on Scientific Affairs. P. John Seward, M.D., of Rockford serves as vice-chairman of the AMA Council on Legislation.

Many others have served on various AMA committees over the years. Pedro Poma, M.D., Melrose Park, serves now as chairman of the Ad Hoc Committee on Foreign Medical Graduates and Dr. Lawrence L. Hirsch, Northbrook serves on a special task force on Professional Review Organizations. Illinois physicians almost continually serve on reference committees (there are eight reference committees of five members each). As an example, in the most recent AMA meeting in Washington, D.C., George T. Wilkins, M.D., of Edwardsville served as chairman of Reference Committee B, which deals with legislative issues.

In addition to electing its own, Illinois evaluates candidates for AMA office from other states and works for those candidates it believes are the most qualified to serve both Illinois physicians and the medical community nationwide. They understand that it is always, fundamentally, an individual who makes the difference.

A Natural Dynamic

The structure of representative democracy is a functional one which fulfills the same needs in a government and a professional association. It enables the individual to derive the benefit of his neighbor's contribution and the opportunity to make one of his own.

ISMS Physician Support Programs

Our Brothers' Keepers

When a physician looks at the benefits of ISMS membership, the picture is one of professional, clinical, legislative and economic programs, publications and activities. But there is another side of ISMS—its commitment to helping the physician and his or her family through personal difficulties.

The Society has created three major resources to meet the special needs of physician families: the Impaired Physician Program, the Physician Support Group and the Medical Benevolence Fund.

The Impaired Physician Program

The impaired physician program is coordinated by the ISMS Committee for the Impaired Physician, a group composed of recovering physicians, medical directors of treatment programs and physicians concerned about their fellow colleagues. While the Committee does not provide treatment services, it does offer counseling, advice, information, educational programs and referral to treatment programs and self-help groups.

In addition, over 50 volunteer physicians serve as members of intervention teams spread around the state. The intervention teams receive and verify calls about impaired physicians and are available to conduct interventions, refer people into treatment programs and support groups, monitor a physician's recovery and serve as his or her advocate before hospital committees and state licensure boards.

All information gathered and used by the impaired physician program is strictly confidential under state law. The fact that a person receives assistance through these activities is not reportable to the state Medical Disciplinary Board.

Information or assistance is available by calling the ISMS Impaired Physician Program at 312-580-2499.

Physician Support Group

As part of its overall initiative to combat the malpractice crisis, ISMS has developed a new resource through its Committee on Loss Prevention Education. The Physician Support Group is designed to help physicians deal with the very real psychological pressures that a malpractice claim can bring about.

Although many persons outside the medical profession suggest that litigation is only part of "the cost of doing business" in today's world, for the individual physician the repercussions of a legal assault are far from inconsequential. Depending on individual circumstances, the personal and professional life of the physician may be profoundly affected.

It is generally agreed that legal action against any individual is a major life stress. For a physician, this is especially true, because it challenges the very core of his or her professional integrity. This, in turn, affects not only the physician-patient relationship but also the freedom to make clinical judgments as they relate to patient care.

When physicians are confronted with a lawsuit, their own personal reactions may become so overwhelming that conflict and tension arise between the needs of the individual physician and the needs of his or her patients.

The Physician Support Group panel consists of volunteer physicians of various specialties who have themselves experienced litigation.

Interaction between the requesting physician and a member of the panel is tailored to meet the needs of the situation. The time, place and subject matter discussed is defined by the participants. All communication is confidential.

One can contact the Physician Support Group by calling the ISMS Office at 312-782-1654, Extension 1145.

ISMS Medical Benevolence Fund

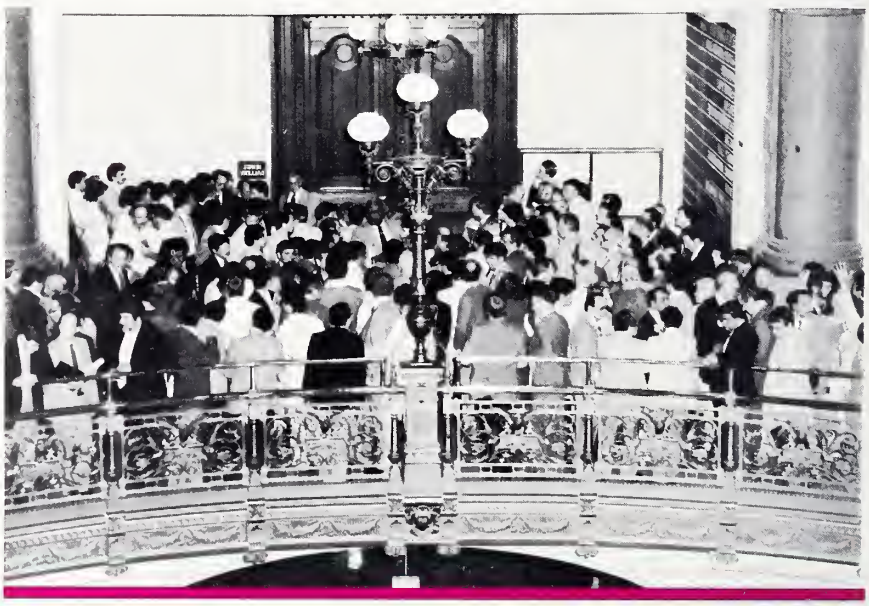
The ISMS Medical Benevolence Fund was established in 1940 to make it possible for economically distressed physicians or their dependents to exist without resorting to welfare. Modest funds are available for daily living and special expenses following one's acceptance into the program.

The potential recipient is asked to complete a financial disclosure form which is to be updated each year.

Any ISMS or Auxiliary member who wants information or knows of someone needing assistance should contact the Medical Benevolence Fund at the ISMS office.

M.D.s Star in Springfield

Political Theater



Each year, the Illinois General Assembly considers hundreds of bills relating to health care and medical practice. While most of these bills do not become priorities for ISMS action, there are usually a hundred or so that are strongly supported or, as is more often the case, strongly opposed. In the 1985 session of the General Assembly, however, there were 20 bills introduced that overshadowed all others. These bills comprised the ISMS malpractice package and defined the thrust of the ISMS Professional Liability Initiative.

The development of the Professional Liability Initiative (PLI) dates to mid-1983, when an ISMS membership survey indicated that the latest insurance crisis was the uppermost concern of Illinois physicians. While this came as no surprise, the survey also revealed that physicians were willing to make a personal commitment of time and effort to support a broad-based grassroots mobilization that would ultimately become the PLI. This finding was particularly important to the decision to move ahead with the PLI. An absence of broad physician commitment would have made the large investment of ISMS resources in the effort a very risky one indeed.

Testing the Waters

The ISMS malpractice bills were introduced in both the House and the Senate in the spring of 1984. According to the rules of each House, legislative sessions in even-numbered years are limited to appropriations and emergency matters as determined by the respective Rules Committees. The bills would have to be voted out of Rules Committee before they could be assigned to a standing committee for consideration.

The Rules Committees balked at reporting the bills. Attorney groups pressed hard to bury the bills, so that they would not even be afforded a public hearing. But ISMS had also lobbied hard to have the bills declared to be emergency measures which merited special consideration. Rules Committee members were flooded with letters and phone calls from the membership. Eventually, the bills were reported and assigned to the Judiciary Committee of the House and Senate.

As anticipated, the lawyer-dominated Judiciary Committees peered at the bills in disbelief. They were surprised that anyone could propose such a drastic change in common law doctrine that evolved over the past 200 years. The Committee allowed the bills to die a gentle

Exercise Your Right and Duty

Vote March 18

In June, Illinois physicians were able to persuade the Illinois General Assembly to pass important malpractice reform legislation. But the real success of the intense lobbying effort can be traced back to the previous November, when the representatives and senators who comprise the legislature were elected.

Illinois voters will again go the polls on primary election day, March 18, to nominate Democratic and Republican party candidates for the November general election. And it's critically important for physicians to be among those who make the effort on primary election day to vote for their state legislators and other elected officials.

We must make the effort to show our support for those incumbent legislators who have supported medicine. And we must work to assist those candidates who will oppose legislators whose voting records reflect a disregard for medicine's important issues.

In addition to all 118 representatives and 39 of the state's 59 senators, those officials up for election include the governor, other leaders of the executive branch of government, the state's entire U.S. congressional delegation, and one of our two U.S. senators. Various county and local officials also will be nominated in the March 18 primary.

The ISMS Public Affairs Committee encourages all physicians, spouses, and family members to participate in this important civic right and duty. But this participation need not to be limited to simply voting in elections.

Physicians and their families should actively support the candidate of their choice throughout the candidate's campaign. This support can take many forms, such as serving on the campaign or finance committee, hosting a coffee, and arranging meetings with local civic groups.

Persons interested in becoming actively involved in volunteer campaign activities should contact the candidate or call the ISMS Governmental Affairs division in the Chicago office for assistance at (312-782-1654).

An absence of broad physician commitment would have made the large investment of ISMS resources in the effort a very risky one indeed.

death by assigning them to subcommittee—a frequently applied action that avoids a direct vote and allows the General Assembly to side-step a tough political decision.

Although stymied in committee as expected, the introduction and limited consideration of the bills served several useful purposes. It demonstrated to the legislature that ISMS was dead serious about tort reform and set the stage for the following year. It revealed that Republican leadership support was strong and Democratic leadership support was extremely weak. It exercised the ISMS membership and exposed the bar groups' strategy to discredit our legislation. It caught the attention of the media and whetted their appetite to continue reporting the issue itself as well as the political theater about to unfold. It was now time to fully organize and implement all aspects of the PLI for next year's war.

Building A Grassroots Organization

In the summer months of 1984, the groundwork was laid to coordinate the grassroots mobilization of the ISMS membership. The PLI organizing unit on the local level was designated as the hospital or the county medical society action team. ISMS staff were assigned geographic regions and were responsible for making presentations and coordinating the activities of the action teams. These activities included the initial presentation to the hospital or county medical society to explain physician and auxilian roles in the PLI; arranging for a physician/legislator meeting to discuss the issue with elected officials; arranging for spokespersons to address civic or business groups to build non-medical support for the PLI and arranging for physicians to meet with editorial boards in an effort to gain media endorsement. All of these functions had to be accomplished within a specific time frame; timing is crucial to successful legislative activity.

As action teams were organizing throughout the state, two other activities were taking place that influenced the future course of events. First, at the urging of legislative leaders, ISMS and the bar groups sat at the negotiating table in an attempt to reach a compromise. While several meetings occurred over several months, it became apparent that no negotiated settlement could be achieved and that a legislative battle would ensue. Secondly, Governor Thompson recognized the seriousness of the medical malpractice insurance crisis and named a blue ribbon panel, the Task Force on Medical Malpractice, to study the issue and form recommendations for legislative consideration. The final product of the task force included sever-

al concepts proposed by ISMS in addition to others that lent credibility to the PLI.

The Winter Session: A Cold War Erupts

As the legislature convened in January, 1985, the Capitol Building buzzed with anticipation for and speculation on the upcoming war between doctors and lawyers—two groups widely recognized as the most powerful in Springfield. Many observers of the legislature pointed to the malpractice issue as the battle of the decade. Those who hoped for an exciting show would not be disappointed.

On April 11, 1985, the ISMS malpractice bills were once again introduced. Identical bills were read in the House and Senate and referred to the Judiciary Committee of each house. The results in committee would be the same as in the previous year with one distinction. This time around, each committee would prove to be an obstruction but not a dead end. There was no giving up this year. The Society would either win a convincing victory or go down with all the barrels empty.

Strategy for Each House

Following the anticipated negative committee actions, a motion was filed in the House by Rep. Sam Vinson (R-Clinton) to discharge one of the ISMS bills, HB 1604, from Committee. If the motion was successful, HB 1604 would serve as a vehicle bill on the House floor to which the remainder of the package could be attached.

A vehicle bill is one which is introduced to provide a mechanism for later amendments. Also called a shell bill, its content is ordinarily routine. As such, it clears committee readily and can be used on the floor to carry controversial amendments which would otherwise not be likely to clear committee.

At this point in the process, partisan politics became an issue—one that ISMS wanted to avoid. The House Democratic Caucus feared that Republicans, who overwhelmingly supported tort reform, would not vote for Democrat-sponsored bills on other issues unless Democrats voted for the mostly Republican-sponsored ISMS legislation. Since Democrats hold a 67 to 51 majority in the House of Representatives and 60 votes are required for passage of legislation, ISMS needed some Democratic support in addition to the 45 or so Republicans likely to vote for the bills. If the issue turned into a purely partisan one, it was likely that Democrats who had previously indicated support would bow to party leadership pressure and vote against ISMS.

This problem was resolved when lead sponsorship of HB 1604 was changed from Rep. Sam Vinson to Rep. Alfred Ronan, a Democrat from Chicago. Following this switch, the motion to discharge the bill from committee for direct consideration on the floor was adopted 115 to 0. HB 1604 was placed on the daily calendar for amendments.

In the Senate, a different strategy was adopted. Rather than filing a motion to discharge committee, it was decided to use a bill already on the calendar that provided a suitable vehicle. Although this bill, SB 1031, did not relate to medical malpractice, it did amend the Code of Civil Procedure—the same chapter of the Illinois Revised Statutes that the ISMS bills addressed. The sponsors of SB 1031, Sen. John Friedland (R-South Elgin), and Sen. David Barkhausen (R-Lake Forest) had introduced the bill to solve a non-controversial problem brought to their attention by a constituent. It was a non-controversial bill that had no opposition. After discussing the situation with ISMS and Sen. Aldo DeAngelis (R-Olympia Fields), the original sponsor of the ISMS legislation, Senators Friedland and Barkhausen agreed to lend their bill to the package and amendments were prepared and filed.

At the same time, SB 1200 was moving through the process. This bill, sponsored by Senate President Phil Rock (D-Oak Park), was initially introduced as the trial lawyers' answer to the malpractice crisis. As far as ISMS was concerned, its response was totally inadequate. Nevertheless, ISMS agreed with Sen. Rock to hold the amendments to SB 1031 and his bill (SB 1200) while legislative leaders attempted to hammer out a compromise.

Classic, Confrontational Politics

It was now early May and the pressure on legislators was very high. The ISMS grassroots effort was clearly having more of an impact than the bar groups' effort. Legislators were receiving 20 or more letters from physicians and auxilians for every one they received from those opposed to the bills. Still, some members of the House and Senate remained adamantly opposed to the bills. Other legislators, who were generally supportive, had objections to two elements of the package—a cap on awards for non-economic loss and a presumptive limit of $25,000 on wrongful death cases. Vote counts on these two issues indicated that they were not likely to pass in 1985. However, there had not yet been a roll call vote on any substantive issue. This would occur on May 16, in the House of Representatives.

The evening of May 16 will long be remembered by members of the House. The atmosphere in the House chambers is normally boisterous. Some members pay little attention to the proceedings at hand, and others move about talking to colleagues about other legislation or the evening's social calendar. This evening, however the debate would capture everyone's

Many observers of the legislature pointed to the malpractice issue as the battle of the decade. Those who hoped for an exciting show would not be disappointed.

The evening of May 16 will long be remembered by members of the House.

attention. Rep. Ronan was allowed by the chair to call HB 1604 at the amendment stage.

Thirteen amendments had been filed to HB 1604 by ISMS sponsors. Amendments one through twelve contained the individual elements to the malpractice package while amendment 13 was an omnibus amendment composed of all the elements. Opponents of tort reform filed 96 amendments to HB 1604 as a way to add objectionable provisions and sidetrack the bill.

The first amendment, dealing with the ISMS structured verdict proposal, was offered by Rep. Loleta Didrickson (R-Homewood). Debate lasted 45 minutes as opponents sharply criticized the entire package and not just the amendment on the floor. Proponents also engaged in debate on the general question of necessary tort reform. As the electronic voting board was closed and verified, it showed 60 voting yes, 57 voting no and 1 absent. Although only a majority of those voting on the question is necessary to adopt an amendment to a bill, reaching 60 votes was important because it would take 60 to finally pass the bill.

As the second amendment was offered, a ruling from the chair dashed ISMS hopes for further progress. The chair ruled that amendments two through twelve were not germane. The ruling was based on a drafting technicality that is, in a practical sense, unavoidable and normally frequently overlooked. But the malpractice legislation was not normal and House Speaker Michael J. Madigan (D-Chicago) preferred that the issue be settled at the negotiating table and not on the House floor.

ISMS, anticipating an adverse ruling from the chair, had prepared the omnibus amendment that could not be realistically ruled non-germane. After tabling the first amendment, amendment #13 was offered by Rep. Tom Ryder (R-Jacksonville). After lengthy debate, the amendment was defeated on a vote of 55 yes, 59 no and 3 absent. Although the amendment lost, it demonstrated that there was broad support for the bills. Further, the opposition of several members who voted against amendment thirteen was soft, while the support of those who voted for it was solid.

At this point it was time to return to the negotiating table. For a month, legislative leaders and the governor's office had been participating in negotiations with ISMS and the bar groups. Lee Daniels (R-Elmhurst), the House Republican Leader, had set up the negotiations and made it clear that substantial reform was one of his priorities for the session. Senate Republican Leader Pate Philip (R-Addison) also was strongly supportive. Speaker Madigan and President Rock, however, were blocking consideration of the legislation to force agreement and protect their members from voting on a controversial issue.

Both Speaker Madigan and President Rock are attorneys with strong ties to the legal community. As leaders of the majority party in the legislature, they continually strive to protect their members from politically tough decisions that could jeopardize their majorities and power. In the case of medical malpractice, it started to become evident to the Democratic leaders



There was no giving up this year. The Society would either win a convincing victory or go down with all the barrels empty.

that the political winds were blowing in favor of the physicians. Not only were physicians and auxilians bombarding the capitol with letters, mailgrams and phone calls, but word had leaked out that 4,000 physicians and auxilians would be descending on Springfield to lobby.

The Rally: Tactics and Timing Come to Fruition

The ISMS rally on May 22, although scheduled months prior to the date, was timed perfectly to coincide with the machinations of the legislature. There had been little progress on the package up to this point. Many legislators who had promised physicians at meetings in their districts to support the ISMS package were reluctant to face their constituents, who would want to know why there had been no progress or why they had voted against the ISMS position on the House floor. It was hoped that their fear would be communicated to Speaker Madigan and President Rock, who would weaken their opposition and agree to meaningful reform.

Two days prior to the rally, a major breakthrough occurred in the negotiations. It was clear that legislative leaders wanted to announce an agreement prior to the rally so that representatives and senators could proudly inform their physician and auxilian constituents that their concerns had been positively addressed. However, although over half of the legislative package was included, ISMS leadership was not satisfied with what was offered. Meaningful reform demanded more.

At ISMS request, Rep. Daniels, Senator Philip and Governor Thompson demanded more for physicians at the negotiating table. On May 22, as rally participants met with legislators, ISMS remained at the negotiating table with legislative leaders, bargaining for more. Interestingly, the bar groups were not included at the final negotiating sessions, but were represented by Senator Rock and Rep. Alan Greiman (D-Chicago), Speaker Madigan's designee.

Shortly after 1:00 p.m. on May 22nd, an agreement was reached that included all but two elements of the original ISMS package—a cap on non-economic losses and a wrongful death provision. House Minority Leader Daniels announced the agreement to the rally attendees assembled on the Capitol lawn. The rally had tipped the scales back into balance. All that remained were some technical adjustments that would be worked out over the next several days.

Shortly after 1:00 p.m. on May 22nd, an agreement was reached that included all but two elements of the original ISMS package.

The Legislature Acts

On the following day, amendments to HB 1604 were filed with the House clerk. It was a busy day in the chamber. The deadline for consideration of bills introduced in the House was one day away and hundreds of bills remained on the calendar. The House convened at 9:00 a.m. and was scheduled to work until 9:00 that night. Amendments to HB 1604 were distributed to the House members in the early evening, along with stacks of other paper that legislators can't be expected to read.

As deadlines approach, the power of the presiding officer becomes more evident. It is the Speaker of the House who controls the fate of most bills, as it is he who determines the order of business and which bills will be called. Much legislation, especially that originating from the party opposite the Speaker, dies on the vine.

The fate of HB 1604 would rest largely on one criterion: whether or not Speaker Madigan would allow the bill to be called.

The pace of business on May 23rd was slow. Partisan debate dragged on for most of the day and little progress was made on the thick calendar. The House would work past the 9:00 p.m. adjournment hour. At approximately 11:30 p.m., just as it appeared that the House would adjourn, the presiding officer called for consideration of HB 1604.

Minority Leader Daniels, who had assumed principal sponsorship of HB 1604, had prevailed on Speaker Madigan to have the legislation considered. Although the bill could have been called earlier in the evening, Rep. Daniels knew that sparks would begin to fly when HB 1604 was considered. He wagered that calling the bill late in the night when everyone was tired would limit debate, especially that generated by opposition members, who had filed 96 amendments.

Representative Ronan was allowed by the chair to call HB 1604 at the amendment stage.

Representative Daniels' plan worked. Amendments 14 through 75 were withdrawn by their sponsors at the outset. Then amendment 76, which contained the agreed language, was offered by Rep. Daniels.

As had happened the week before, when HB 1604 was called the first time, a hush fell over the chamber. Rep. Daniels skillfully explained the complex amendment and asserted that it would neither hinder a truly injured plaintiff access to the courts nor interfere with full recovery of damages. Opponents of the amendment, speaking for the bar groups stung by the leadership agreement, argued that physicians were asking to be treated as a special class. They claimed that increased suits were

due simply to increased negligence. They cited timely examples of well publicized instances of clear negligence, in which a journalist and a pregnant woman had been injected with the wrong substances. Rep. Daniels countered that, although these cases were clearly tragic, his proposal would not affect the right to trial or full recovery of damages.

The debate went on for 45 minutes. The faces of most representatives looked drawn and tired. The vast majority could not grasp the legal aspects of the legislation, but had to make a judgment on what seemed right and fair. The decision weighed heavily on many members. As the electronic voting board closed, it showed 96 voting "yes" and 16 voting "no." The amendment was overwhelmingly adopted.

Six more amendments were considered that night. All of them were sponsored by opponents of tort reform. All of the amendments failed.

Rep. Daniels then made a motion to suspend the rules to allow for consideration of HB 1604 on third and final reading. Normally, a bill amended on one day must sit on the calendar until the next day for final passage. But the motion to suspend the rules prevailed and HB 1604 was passed 103 to 11 at 12:30 a.m. on May 24.

The bill now moved to the Senate. There, it was fine tuned over the next few days and passed 57 to 0.

The Aftermath

House Bill 1604 was formally passed by the legislature on June 18. It landed on the Governor's desk two days later and was signed by Governor Thompson on June 25 in the presence of ISMS leadership and legislative sponsors. Shortly afterward, Chicago attorney Leonard Ring filed suit in Cook County to question the constitutionality of major provisions in HB 1604. On December 18, Circuit Court Judge Joseph Wosik ruled that five elements of the ISMS malpractice package were unconstitutional. Just like that!

"Routine" Issues are 12% of Agenda

Business As Usual

Although preoccupied with professional liability legislation throughout the 1985 session, ISMS was largely successful in eliciting support for medicine's position on other bills as well. One exception was the issue of establishing "preferred provider organizations" (PPOs) in Illinois. ISMS went head-to-head on this issue with a coalition formed by major business groups, labor unions, insurance companies, consumer groups and the Illinois Hospital Association. ISMS fought for provisions in the PPO bill to guarantee patient freedom of choice in selecting a physician and hospital, and a guaranteed minimum patient reimbursement level for treatment by non-preferred providers.

ISMS countered the PPO bill with a proposal to establish the "Voluntary Medical Services Contracting Act." This legislation would have allowed any physician offered a contract for medical services to participate in a collective discussion of terms with other such physicians and the party offering the contract. Physicians would still have been required to sign contracts on an individual basis.

This legislation is needed to exempt such activity from antitrust law, which may now create problems for such activity. The bill was opposed by the same coalition which had supported the PPO bill; it failed to attract sufficient support for passage. ISMS will continue to press for this important legislation.

Although most of the attention in the Illinois General Assembly was focused on medical malpractice reform, literally hundreds of other issues were introduced and considered by the legislature. Representatives and senators introduced 3,891 separate bills in 1985 (in addition to the plethora of amendments and resolutions). ISMS found 242 of these bills to be of primary concern to public health and medical practice. Bills designated as "primary" demand closer attention than the 237 "secondary" bills also monitored and lobbied by ISMS. These numbers suggested that the legislature devoted 12% of its agenda to measures related to health care in the 1985 session.

The percentage of bills affecting health care has increased dramatically over the past few years, as non-physician health professionals, business, labor and consumer groups have taken a greater interest in licensure, health care economics and quality issues. Legislators, who once relied solely on the medical lobby for advice on medical issues, now must respond and be accountable to other active constituencies. For the medical community, this simply means that increased political/legislative activities will be required to maintain influence in the General Assembly.

One must wonder how one person can overturn a law agreed upon by the duly elected 177 members of the state legislature and the Governor. But such is the constitutional power vested in members of the judicial branch of our government. Of course, the Circuit Court decision has been appealed directly to the Illinois Supreme Court, where a decision is expected in late March or early April. While the legislative and executive branches of government are sources of great power in our society, the judicial branch seems to hold the important balance of power.

Previous decisions by the Illinois Supreme Court indicate a limited willingness to place medical malpractice tort law in a special class. Then again, the Court has voiced objections and overturned various medical malpractice laws in the past. While the previous decisions of the Illinois Supreme Court were carefully studied prior to drafting the ISMS bills, one can only hope that the lower court decision will be overturned.

Regardless of the upcoming court decision, ISMS will continue efforts to bring balance to a tort system that threatens the availability of quality health care in Illinois. Plans have already been made to introduce legislation in the 1987 session of the Illinois General Assembly to cap awards for non-economic losses and perhaps change the current statute of limitations for filing malpractice suits.

One thing remains certain. The medical community must increase its political involvement on the local level if successful and lasting reforms are to be achieved. Those who opposed ISMS in the legislature last year recognize that grassroots organization and a willingness to become involved are keys to success. They no doubt will take steps to more effectively combat our efforts.



"It Takes A Little Effort"

Dr. Jane Jackman, a Springfield family practitioner, became active in ISMS through the Professional Liability Initiative. But she has found that malpractice isn't the only medical issue that demands physician involvement in the political process.

"As I became more active in ISMS, I realized that there are hundreds of health care-related bills introduced in the legislature each year," says Dr. Jackman. But while she agrees that the society's lobbyists do a good job in dealing with them, she argues that lobbyists are helping only to a degree. For maximum effect, "legislators have to hear from a constituent," says Dr. Jackman.

Before the malpractice effort, too few physicians had ever made personal contact with their state representatives or senators, according to Dr. Jackman. Her own legislators, at first, "were surprised to hear from me," she adds.

For Dr. Jackman, the experience proved enlightening for both the legislators and herself. "I was surprised to see how easy lobbying is," says Dr. Jackman. Arguing that any physician can and should become an effective lobbyist, Dr. Jackman says a brief letter or telephone call is usually all that's required. "It takes a little effort, but not too much," she concludes.

Dr. Jackman chides physicians who aren't members of ISMS and organized medicine. She says those who have refused to join benefit from Society activities but are "getting a free ride." She argues that every physician needs to belong to organized medicine to help the profession cope with increasing economic, legal, and other pressures.

Dr. Jackman's involvement in the ISMS malpractice drive also led her to realize the need for physicians to make an effort to discuss major health issues with lay audiences and the news media. When ISMS' legislative proposals were under consideration by the General Assembly, Dr. Jackman agreed to debate a representative of the trial lawyers' association on a Springfield television show. While Dr. Jackman admits she agreed to the televised debate with "some trepidation," she says she felt strongly enough about the issue to "take it on."

Dr. Jackman encourages her colleagues not to shy away from discussing major health issues with lay audiences and members of the local news media. She maintains that such sessions should be approached in the same way that a physician counsels his or her patients.

"It's not that different from what physicians have to do in their daily practices," says Dr. Jackman. "If you know your audience, you'll do OK." Dr. Jackman says she found public speaking training sessions offered by ISMS at recent membership meetings to be especially helpful in preparing her for public appearances.

People with a Purpose

Organized medicine faces many challenges today, and so does its Auxiliary. We are your other half. We go together. We are the first line of support for our physician spouses.

In Illinois, the Auxiliary has a potential membership of nearly 12,000. We actually number under 2,600. Membership is the life blood of any organization, and the life blood of your Auxiliary is in need of more platelets. We are a leader in this nation in legislative efforts. Many states have requested our Auxiliary program for legislation so they can assist their medical society in a professional liability initiative.

The benefits of membership are multifold. The most important element of the Auxiliary is concern for the quality of health care for all. The friendships that are made are another important element. We, your spouses, are concerned about you, and the better we understand the practice of medicine today, the better we can understand your daily problems.

Membership in the federation—county, state and national—affords us unlimited benefits; some tangible and some intangible. We have time to do the things that a busy physician may not. We can write letters to legislators, make phone calls and lobby in Springfield. We can entertain legislative spouses at our luncheons to show them we are friends. We are a support group for those who need friends in difficult times. We change negative attitudes on the part of the public, and we help raise funds for Illinois medical students and insure the quality of education in our medical schools through AMA-ERF.

The medical Auxiliary is unique. We are a special entity. We are proud of our accomplishments. It all begins with being the spouse of a physician. We need each other today. The future of medicine is in legislation, publicity and public relations. These are areas in which the Auxiliary can work . . . where we are being trained and where we can do our share in helping our spouses show we are a caring organization.

Many spouses work and are not able to participate actively. What we need is their support. In order to continue to be effective, we need to say, "Yes, we represent the majority of Illinois physicians' spouses." That lends a credibility not easily replaced—a credibility which enables us to help each other, you the physician, and our communities. Perhaps the working member could offer us a program—or perhaps she/he would just like to be a supportive member. We have so much in common.

If your spouse is not a member of the Auxiliary, please accept this as a personal invitation to join us. You need us and we need your spouses' memberships. We can do more together, because we are people with a purpose.

A note from the North Dakota Auxiliary:

Yesterday—

The AMAA was formed to encourage fellowship among doctors' families.

Today—

It is a driving force for good health among the people in the United States.

Tomorrow—

It will strengthen to keep medical practice and health care at high levels—if you join us and add your voice to ours.

For more information regarding Auxiliary programs and membership, please contact the ISMSA, Twenty N. Michigan Avenue, Suite 700, Chicago, IL 60602, (312) 782-2099.

Each A Fundamental Forum

County Medical Societies

The county medical society is an important cog in the machinery of organized medicine. "If you don't have a strong county medical society, you're not going to have a strong state society or AMA," says Dr. Frederick J. Heinzen, immediate past president of the Peoria County Medical Society.

But most county medical society officers and executives would agree that the real need for a county medical society is to give physicians a mechanism to deal with local issues. Dr. Heinzen maintains that with all the divisive influences confronting the profession, the county medical society is "the one organization that has any chance of unifying physicians."

Dr. Heinzen further argues that the role of the county society is especially critical in those counties with more than one hospital. With more than one hospital operating in a county, "you're going to get divisiveness and polarization," Dr. Heinzen says.

County medical societies offer hospital-based physicians an important opportunity to interact with their colleagues "out there," Dr. Heinzen explains. He adds that the county society can provide a refuge to address matters where the interests of physicians and hospitals collide.

Important Forum

"The hospital's goals are not necessarily the same," says Dr. Erlo Roth, immediate past president of the DuPage County Medical Society. "Physicians need a forum to discuss medical issues unencumbered by the presence of hospital administrators."

In addition, hospital medical staffs must concern themselves primarily with issues relating to care rendered in that hospital, says Jane Stein, executive director of the Lake County Medical Society. As a result, they sometimes avoid looking at "the big picture."

Likewise, neither state nor national medical organizations can fulfill the role of the county medical society in many areas. "How is a national organization like the American Medical Association going to deal with a city council in Peoria?" asks John Hanni, executive vice-president of the Peoria County Medical Society.

Lillian Widmer, executive administrator of the DuPage County Medical Society, points to liaison with local agencies as a key aspect of county medical society activities. She says the local health department and other county agencies often come to the DuPage society when they need physician advisors or help with local health issues.

The county medical society also initiates local health care programs. Dr. Roth tells how the DuPage society was instrumental in organizing a coalition of local agencies, town officials, and health professionals, to develop a program to provide medical care for those patients who could not afford it.

Physicians Comfortable

County executives point to their societies as places where physicians are more "comfortable." According to Stein, "physicians are more comfortable in their local environment. They know the people. They know the politics." Many physicians look upon their county societies "as family," says Stein.

Most physicians find it easier to function at the county level, Stein adds. "The larger the organization, the more lost they feel. Frequently, physicians with a question won't know who to contact at ISMS or the AMA. They know they'll get an answer from me," says Stein.

Nonetheless, county medical societies do not operate in a vacuum. They perform critical functions with respect to their state and national affiliates. "County medical societies are in a good position to provide backup support for Illinois State Medical Society activities," says Fred Schwartz. Schwartz is executive director of the Chicago Medical Society, which represents Cook County.

Schwartz points to legislative activity as an area where county medical society support is especially important. "A major effort on our part is to strengthen the ability of

ISMS to be effective in the state capitol," says Schwartz. He emphasizes the vital support that the Chicago Medical Society and other county societies gave to ISMS' recent initiative for malpractice reform legislation.

"My feeling is that if the county medical society had been distant and uninterested, it would have decreased physicians' sense of urgency," says Schwartz.

Many county medical societies played important roles in the professional liability initiative. They organized physician contingents for the May 22 Springfield rally, undertook media liaison and arranged physician appearances before civic groups.

Dr. Roth echoes the assessment of the importance of county medical society involvement in legislative and political activity. "The more that government gets involved in medicine, the more medicine must get involved in politics," he adds.

The DuPage society plays an important role in ongoing legislative activity. "It's much easier for the county medical society to arrange meetings between legislators and constituent doctors," says Widmer. However, that task is not always easy, since some 17 different legislative districts contain parts of DuPage county.

Educational Efforts

County societies offer a wide array of continuing education programs for their members. But most county execs agree that they cannot compete with hospitals or specialty societies in the clinical area.

"Most physicians turn to their hospital for medical issues and turn to their county medical society for socio-economic issues," says Stein. For example, the DuPage society recently sponsored a program designed to help physicians defend themselves in malpractice suits. The Chicago Medical Society has offered a series of practice management seminars.

Nonetheless, counties have not abandoned presentation of clinical topics. The largest of these offerings is the Chicago Medical Society's annual Midwest Clinical Conference held each spring, which draws as many as 1,500-2,000 attendees.

County medical societies also provide important training to physicians interested in becoming effective medical leaders. Most physician officers of ISMS and the AMA at one time served as county medical society presidents or officers.

"We prepare physicians to move up the ladder of organized medicine," says Hanni. County society committees and leadership posts give physicians the opportunity to identify their interests and hone the political skills necessary to be effective leaders.

The county executives interviewed all agree that personal involvement by its members is the real strength of any county society. "The fact that physicians are paying their dues means that they're interested in what the county society is doing," says Widmer. But that's not always enough, she says.

According to Widmer, involvement in society activities does not have to take much time. Nor does a physician have to labor for many years before he or she is recognized as a leader. Widmer says physicians have been elected president of the DuPage society within two or three years of becoming active in the society's activities.

Public Programs

In addition to activities of interest solely to the medical profession, county medical societies are deeply involved in a wide range of programs designed to promote the profession's image among members of the general public. "For one, the county society is the focal point for peer review," says Schwartz. County societies handle patient complaints.

Another public-oriented activity is physician referral. County societies provide an important resource to members of the community seeking physicians. Most county society executives are quite familiar with their members and can refer patients to pertinent specialists.

Skilled Administrators

Keeping the variety of county medical society activities running smoothly is a difficult job. And to better accomplish this task, most larger county societies have retained the services of professional administrators.

Widmer says the type of individual needed for such a post is much different than when she became DuPage county's executive administrator some 25 years ago. "The issues faced by county societies today are much more complex, and they demand professional and trained executives," says Widmer.

Stein says that, in addition to her business degree, she finds her training as a nurse especially helpful in administering the Lake County society's activities. "I know what the physicians do," says Stein. "I know the patients they take care of, because I took care of them too."

Stein says the most important function of a county society executive is that of communicator. She points to the society's newsletter as a particularly important communication vehicle. "For three-fourths of the members," says Stein, "it's the only contact that they may have with the society."

Another important function of the county society executive is to provide continuity, says Hanni. With physician leadership changing annually or every 2-3 years, the executive plays a key role in the continued smooth functioning of the society.

Also important, says Hanni, is a good relationship with other county society executives. "Knowing about a particular situation in another county can help me better anticipate problems in Peoria," says Hanni.

To facilitate communication between themselves, the county society executives have formed their own organization. Meetings are usually held in conjunction with ISMS Board of Trustees and House of Delegates meetings. Hanni currently serves as that organization's president.

Strategies for Meaningful Enforcement

Medical Discipline

By Alfred J. Clementi, M.D./Arlington Heights
Chairman, ISMS Board of Trustees
Chairman, Governor's Task Force on Discipline

"Spare the rod, spoil the child" is an axiom upon which parents have long relied to rear well-balanced offspring. Despite the oversimplification, these words aptly describe current public perceptions of doctors. Many public policymakers, media representatives and patients substitute "medical profession" for "child" in the above maxim. For too long, they say, we have "spared the rod" within our own ranks, thus contributing to the ever growing dockets of medical malpractice litigation and dimming public confidence in the quality of medical care.

This perception is inaccurate. Medicine has made great strides over the last decade to improve the quality and conduct of its practitioners. Yet the perception persists. The medical discipline issue doggedly pursued Illinois physicians as we spoke out on the need for medical malpractice reform last year. Why does not the profession do a better job of policing its own ranks? How many physicians have had licenses revoked this year? Why has Dr. "X," previously disciplined in Illinois, been allowed to move to another state and easily establish a new practice? We heard these questions again and again.

As we continue our campaign to moderate Illinois' civil justice climate, now is the time to meet four-square the medical discipline issue which casts a shadow on all medical professionals. Three programs of action seem appropriate.

Public Education Needed

Public education is a key to improving the profile of medical discipline and to providing patients with the knowledge to complain about bad doctors and bad medicine. Many medical disciplinary and peer review mechanisms are already in place—through both the state Department of Registration and Education and Illinois' county and state medical societies. If our patients are armed with the knowl-

Governor's Task Force on Discipline

This recently-established group is looking at ways to improve laws, regulations and procedures governing our medical disciplinary system here. Its members are:

Alfred J. Clementi, M.D., Task Force Chairman
(Chairman, ISMS Board of Trustees)
Gary L. Clayton
(Director, Department of Registration and Education)
David S. Fox, M.D.
(Chairman, Medical Examining Committee)
Harold L. Jensen, M.D.
(President, Chicago Medical Society)
Morgan M. Meyer, M.D.
(President, ISMS)
Jeffrey C. Miller
(representing Governor James R. Thompson)
Rischer Watts, M.D.
(Chairman, Medical Disciplinary Board)

Input from physicians for Task Force deliberations is welcome. Please send any comments to ISMS, Twenty N. Michigan Avenue, Chicago, Illinois 60602.

edge to report incompetence to appropriate authorities, they can become valuable allies in improving the reality and perception of medical discipline.

Another public education need is also apparent: letting legislators, media, patients and other key constituencies know how doctors have worked to improve medical discipline over the last several years—providing examples, if possible, of how credentialing, peer review, mandatory reporting and other procedures have assured quality health care in a particular community or hospital. I am not suggesting that specific disciplinary proceedings against a medical professional be turned over to the media for public debate. That is clearly a violation of ethics and due process. Rather, I am suggesting that those in charge of various hospital and medical oversight functions speak out regularly on why those functions exist, how they interrelate as "checks" in the health care system and why the "balances" of confidentiality and due process are crucial to their continuing integrity.

Improving the System

The second program for action involves realizing that our medical disciplinary system, while vastly improved and superior to those in most states, is not perfect. Improvements are always in order. Toward that end, Governor James R. Thompson has established a Task Force on Discipline to examine the current system and recommend ways to better it. ISMS chairs the group and has appointed several Task Force members. The Task Force is also searching for a new medical coordinator, the chief enforcement officer of Illinois' Medical Disciplinary Board. As of mid-January the Task Force had met four times. Its appointment is open-ended; a report will be issued once conclusions are reached.

One certain topic the Task Force will investigate is the time lag between the arrival of reports and complaints at the Department of Registration and Education, and the final disposition of those medical disciplinary cases. Legislation in the last several years has boosted the information flow to Illinois government enforcers of medical licensure and discipline. The result has been an often long investigation backlog. Steps to expedite these medical disciplinary examinations and subsequent proceedings may be in order.

Renewed Personal Commitment

The third area for action involves a renewed personal commitment by all medical professionals to ferret out and remove incompetence and impairment among colleagues. Doctors, hospitals and others in the medical profession must, and to a large degree have, become activists. Those in medicine who cite disciplinary system inadequacies are often the ones who refuse to search out poor practitioners—and once found—do not report them to the

How the State and Physicians Police Illinois' Medical Profession

Health Care Quality Control

- *The Illinois Department of Registration and Education* licenses all physicians. Only the state has authority to revoke or suspend a doctor's license to practice medicine here.
- The *Medical Disciplinary Board,* created in 1975, oversees and disciplines Illinois' medical profession. The Board has served as a model for other states' disciplinary functions.
- In 1982, the Illinois legislature approved a *Mandatory Reporting Amendment,* which requires hospitals, medical malpractice insurers, medical societies and others to report any negative action taken against a doctor to the Medical Disciplinary Board.
- The Illinois State Medical Society vigorously supported establishment of the Medical Disciplinary Board and the subsequent Mandatory Reporting Amendment. *Illinois physicians voluntarily doubled their licensure fees* to fund the Board initially and increased them again in 1982 to strengthen investigations through mandatory reporting.
- Since 1982, Medical Disciplinary Board actions against physicians have increased 73%, a signal of its growing effectiveness.
- The Illinois *Hospital Licensing Act* and the *Joint Commission on Accreditation of Hospitals* lay out strict standards regarding the quality and appropriateness of patient care. Doctors on hospital staffs must participate in and submit to regular, frequent peer review.
- The federal government, a $4 billion purchaser of health care benefits in Illinois, sets out quality and cost control standards through use of *Physician Review Organizations* and "Diagnosis Related Groups."
- Illinois' state and county medical societies review consumer complaints against physician members through a *peer review process.* Any negative finding is reported to the Medical Disciplinary Board.
- *Loss prevention programs,* sponsored by ISMS and its affiliated physician-owned medical malpractice insurer, help doctors avoid potential malpractice situations.
- The ISMS *Committee for the Impaired Physician* aids doctors affilicted with drug or alcohol dependency. Those who receive treatment have a 93% chance of returning to full professional practice.

The Illinois State Medical Society has developed a white paper on the medical discipline issue. To obtain a copy, please call the ISMS Division of Public Relations at (312)782-1654 or 1-800-782-ISMS.

Disciplinary Board. Many physicians are satisfied merely with removing bad colleagues from the hospital staff, fearing litigation if the information is passed on to the state.

We must not allow such fear and laxity to persist. There is nothing so disconcerting to good doctors as to be painted with the same brush as bad ones. We need to sweep these people out of medicine. We gain absolutely nothing by hiding them. The Governor's Task Force is discussing methods to improve organized medicine's investigatory abilities. Perhaps now is the time for ISMS to ask the state to grant us broadened investigatory authority, so that more focused and timely peer review can be accomplished.

One positive development is the enactment of an immunity provision for those doctors and hospitals who revoke, suspend or otherwise limit medical staff privileges of impaired or incompetent physicians. Signed into law in August as part of the medical malpractice reform package, this measure should facilitate disciplinary action within hospitals. For too long, those medical professionals speaking out and acting on disciplinary investigations have been slapped with lawsuits by the party being disciplined. Illinois' new immunity provision, modeled after a similar Arizona law, will correct this.

If we constructively address these three areas—public education, medical disciplinary system improvements and renewed personal activism to eliminate bad medicine—public perceptions will more clearly reflect the good work and real progress to date in building a strong medical disciplinary system here. Continued vigilance on each of these three fronts will pay off in heightened patient confidence and in better medicine being practiced throughout the state.



"It Really Taught Me How Democratic the System Is"

"I now know that one person can make a difference," says Belleville psychiatrist Dr. Silvana Menendez.

Dr. Menendez will be the first official spokesperson for hospital medical staffs at the 1986 meeting of the Illinois State Medical Society House of Delegates. Her election as delegate follows creation of ISMS' Hospital Medical Staff Section last April.

Dr. Menendez says she had resisted joining ISMS because of the "unified membership" stipulation that requires ISMS members to join county medical societies and the American Medical Association. She had reservations about joining the AMA, but credits ISMS Secretary-Treasurer Dr. Ron Welch for convincing her that ISMS membership and active participation in the society was essential to her professional life.

It was not long before Dr. Menendez had a voice in the deliberations of the organization she had resisted joining. When the AMA formed its Hospital Medical Staff Section, Memorial Hospital in Belleville appointed her as its representative.

At the first meeting of the AMA's Hospital Medical Staff Section, Dr. Menendez met with other representatives from Illinois and worked for the election of an Illinois physician, Dr. Sandra Olson, as an at-large member of the AMA Section's Governing Council.

Dr. Menendez also volunteered to serve on a committee that would develop an organizational plan for the Illinois section representatives. That committee acted as liaison between ISMS and the Illinois members of the AMA section.

When the committee decided to seek creation of a similar hospital medical staff section at the state level, Dr. Menendez advocated its position at reference committee hearings and on the floor of the House of Delegates. Following formation of that section, Dr. Menendez was elected its delegate to the ISMS house—a post she will assume at the April 4-6 ISMS Annual Meeting.

"When I got involved in the AMA Section," says Dr. Menendez, "I realized that you can bring a problem or an idea from the most remote area of our state and have a voice in helping change the future of our profession. It really taught me how democratic the system is."

WHY JOIN?

By Lauren Baker/ISMS-MSS Chairman

Why join organized medicine? I asked myself this question many times at the beginning of my medical education. The special student membership rate was not a huge sum to part with, but what was I to receive in return? Benefits of membership include the excellent publications, such as the *Journal of the American Medical Association (JAMA),* the *Illinois Medical Journal,* and *American Medical News,* a choice of a national specialty journal, and various county publications. Was I really going to be able to find the time to read all of them anyway?

Or maybe, I thought, I might get involved. But I was already overextended in college extracurriculars and remained wary of commitment. After all, medical school consumes a great deal of time. Taking a chance, I joined with the attitude that I might learn something. I have not regretted that choice.

Gradually, I was exposed to terms like DRG, PPO, IPA, EPA, PRO, HCFA, TEFRA, GME and LCME. In the search for words to replace abbreviations, I turned to the medical periodicals I received as a result of my membership. There I was able to differentiate practice contract language from government agencies and graduate medical education vocabulary.

Eventually, the acronyms, although still annoying, were no longer just abbreviations. I understood their meaning and their impact on the medical profession—my profession. Grudgingly, I began to acknowledge the evaporation of my naivete. Doctors could not practice medicine in their ivory hospitals and offices leaving politics for the politicians, economics for the economists, tort reform for the lawyers, and ethical issues for the U.S. government.

With a raised consciousness, I saw organized medicine from a new perspective. All levels of organized medicine are actively involved in confronting the issues, many of which directly concern medical students and their future medical careers. I learned of the dwindling funds of HEAL loans and the National Health Service Corps, of the government's proposed Medicare funding cuts for graduate medical education, which jeopardize the salaries and durations of residency programs nationwide. Most importantly, I learned of the efforts of organized medicine in combatting these problems. The time to sit by and watch the approach of unpaid residencies and unwieldy professional liability insurance premiums and settlements, hoping they'd all go away, was gone. It was time to speak out. Organized medicine, from the county level to the national level, provides an excellent forum for medical students to make their concerns and views known.

At the state level, the Illinois State Medical Society has established a Medical Student Section (the ISMS-MSS). An ISMS-MSS representative enjoys full voting privileges as a member of each major ISMS council. The ISMS-MSS is represented in the ISMS House of Delegates via a delegate and an alternate delegate. And the ISMS-MSS submits policy-making resolutions to the ISMS House of Delegates.

At the national level, the American Medical Association has also established a Medical Student Section (the AMA-MSS). Again, medical students enjoy full voting privileges as members of major AMA councils. Again, the AMA-MSS is represented in the AMA House via a delegate and an alternate delegate and may submit resolutions to that governing body. In addition, a medical student now sits as a member of the AMA Board of Trustees.

Organized medicine needs and wants medical student input and has provided us every opportunity for participation. Medical students are involved in rallies, medical political action committees, task forces and ad hoc committees. All activities educate the physician and his or her patients to growing crises and their impact on patients' rights to quality medical care. There are so many opportunities for medical students to get involved or to express their views.

Personally, membership and involvement in organized medicine has equipped me with the skills to meet the previously mentioned challenges. Involvement, time and experience strengthened my leadership, organization and brainstorming skills. Through the years, I have acquired a data base and a wealth of information and practical knowledge which I never gleaned from formal medical school lectures or rounds. Joining organized medicine has provided me with an invaluable education. It has widened my perspective and given me a foundation on which to understand and perhaps to effect change, as the face and future of medicine continues to evolve.

Why join? Because you can't afford not to—your future in medicine may depend on it.

For more information regarding medical student membership and the benefits of membership, contact either your local county medical society or the ISMS-MSS at Twenty North Michigan Ave., Ste. 700, Chicago, IL 60602 (312-782-1654).

An Opportunity

Resident Physician Membership

By Michael Davidson, M.D., Chairman, ISMS/RPS

Physicians today face many serious issues. These problems, which include rapid escalation of health care costs, industrialization of medical practice, increasing government regulation, physician oversupply, and the need for professional liability reform, are at least equally important to the resident physician. Professional medical organizations, such as the American Medical Association and the Illinois State Medical Society, seek to cope with these issues. The first objective is to maintain the quality of the greatest medical care system in the world.

Quality of care is one of many issues which concern the private practitioner, the academic physician, the HMO physician, and the corporate physician. Membership in organized medicine is appealing to a wide variety of physicians united for the cause of patient care.

Quality of care is also critical for the resident physician, but it is likely that funding of graduate medical education is presently of more immediate concern. Membership in organized medicine insures that our needs are addressed on the local, state and national levels.

On the National Level

The American Medical Association Resident Physician Section (AMA/RPS), just a little over ten years old, is now the fastest growing segment of the AMA, with over 30,000 members. In addition to growth in numbers, the RPS has made substantial gains in influence within the AMA. A resident now sits as a voting member of the AMA Board of Trustees and every major AMA council has a resident member. The AMA is listening and reacting to the resident's perspective. Residents and other young physicians are playing a major role in shaping the future of American medicine.

Funding of graduate medical education by Medicare is now being examined in Congress for budget reductions. At this writing, the exact nature of the budget reductions is not yet final, but the federal government has already stated that funding of specialty training and the training of foreign medical graduates may be eliminated. This would effectively limit the number of specialists rather than allow competitive market forces to make that determination. For residents, this could mean that the nature and quality of specialty training programs may change radically and the number of programs may be reduced dramatically. It may represent only the first step of federal government withdrawal from support of resident training altogether. Already, the number of residency positions is declining and many graduates are not able to secure a residency in the specialty of their choice. The RPS, along with other segments of the AMA, have strongly advised Washington legislators of the need for adequate funding to maintain high quality of graduate medical education in the United States.

The AMA/RPS has also closely examined the environment of the resident physician and formulated plans to improve it. Many important AMA resolutions, such as those concerning hepatitis vaccination of health care workers, anti-smoking education and AIDS research, have been sponsored. On the national level, the RPS has achieved prominence as the voice for residents within the AMA and in general.

On the State Level

The Illinois State Medical Society Resident Physicians Section (ISMS/RPS) continues to be a very active and effective component of the national RPS. An Illinois member, Ronald Davis, was the first resident to be elected a voting member of the AMA Board of Trustees. He continues to hold that position, and

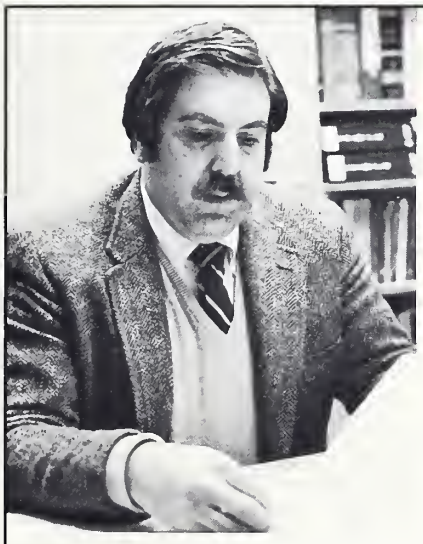
is respected throughout the AMA. Ira Friedlander, a cardiology fellow at the University of Chicago, is the resident member of the AMA Council on Scientific Affairs, and Frank Pieri, a psychiatry resident at the University of Chicago, is the resident representative to the AMA Impaired Physicians Advisory Committee.

Residents are full voting members on each of the ISMS' seven major councils. Michael Nieder, a pediatric resident at Children's Memorial Hospital, currently serves as a delegate within the Illinois Delegation to the AMA House of Delegates. Rockford Yapp III is the ISMS/RPS voting delegate within the Illinois State Medical Society House of Delegates. Representation enables the resident physician to influence issues effecting graduate medical education at the state level.

The ISMS/RPS seeks to make the concerns and problems of the resident physician known and to take action on them. Seminars throughout the state have informed residents that our organization is concerned about their education and future. Participation of all residents, including those with strong academic career interests, is essential to effectively address the serious problems that face all of us, now and in the future.

Many residents join organized medicine for the numerous services that membership provides. But more and more are starting to join out of concern for the increasing problems facing our health care system. We need your support so we can address these problems as a united group, rather than a splintered voice with little effectiveness. Our organization provides an opportunity for individuals to contribute and express their views. The RPS is seeking the active support of its members. If you have ideas or perspectives you wish to express, the RPS provides a forum where these views can be articulated and acted upon.

Despite some problems, the future of medicine remains bright because the physicians of the future are taking action to determine their own destiny. Organized medicine provides an excellent framework to address resident concerns. It's up to us to implement our solutions as effectively as possible. Any individual can make a substantial impact. We need your membership and support to help us maintain the quality of patient care we have trained so hard to achieve.



Hospital Medical Staff Section was the Key

Dr. Lawrence Stone first joined the Illinois State Medical Society for the malpractice insurance benefits offered through the Illinois State Medical Inter-Insurance Exchange. And although his interest in organized medicine waned when he dropped his coverage with the Exchange, Dr. Stone soon found that it offered more to him as a physician than just malpractice coverage.

What rekindled Dr. Stone's interest was the newly-created American Medical Association and ISMS Hospital Medical Staff Sections. As a hospital-based oncologist, he says he finds the state HMSS more satisfying than local branch meetings of his county medical society. "It's clear to me that the Hospital Medical Staff Section is interested in the kinds of things that interest me in my practice," says Dr. Stone.

Dr. Stone became intricately involved in medical staff issues when the chief of staff of Lutheran General Hospital in Park Ridge asked him to be the hospital's representative to the AMA HMSS. Later, he helped form the ISMS counterpart, and last year was elected an at-large delegate to the Illinois Section's Governing Council. He has attended every AMA HMSS meeting and all Illinois caucuses. And he served as a subcommittee chairman of Reference Committee C for the Illinois Section during the December meeting of the AMA in Washington.

But Dr. Stone's interest in organized medicine goes beyond medical staff issues. He was very active and committed to malpractice reform, serving on the hospital's action team that was organized as part of the ISMS Professional Liability Initiative. And he was part of Lutheran General's Springfield rally contingent.

Dr. Stone is keenly interested in the changing patterns of health care delivery and payment. Health maintenance organizations, preferred provider organizations, and independent practice associations are "reaching deeply" into the physician community, he says. He maintains that as more members are affected by the movement toward alternative delivery systems, ISMS will have to devote more of its resources to the issue. He cited ISMS' new Office of Contractual Services as an important step in this area.

There When You Need It

ISMS Insurance Programs

One of the most important benefits available to members of the Illinois State Medical Society is professional liability coverage through the Illinois State Medical Inter-Insurance Exchange. Also available are insurance plans for ISMS members, their families and their employees.

The Illinois State Medical Inter-Insurance Exchange is in its 10th year of providing malpractice coverage to Illinois physicians. The company was started at the height of the malpractice crisis in the mid-1970s, when the commercial carrier underwriting an ISMS-sponsored program demanded a 270% increase in premiums. The need for creation of the Exchange was intensified by the refusal of other commercial carriers to underwrite coverage.

Since its inception in 1976, the Exchange has grown in size and scope. Some 7,700 physicians were being insured by the Exchange at the end of its first policy year. By year-end 1985, that number had grown to more than 10,000 individual and corporate policyholders.

In its initial years of operation, the Exchange offered only coverage limits of $100,000 per incident/$300,000 per year and $1 million/$1 million. Today—recognizing physicians' need for more protection—the Exchange offers six different packages of coverage—up to a $5 million/$5 million option.

To date, the company has limited its offering to the "occurrence" form of policy. However, the continually worsening malpractice climate has forced the company to offer only "claims-made" coverage beginning with the July 1, 1986 policy year.

The Exchange is totally owned and operated by physicians. The 21-member Board of Governors is comprised of physicians elected by the policyholders. Day-to-day operation of the Exchange program is handled through Illinois State Medical Insurance Services, Inc., a wholly-owned subsidiary of ISMS. A six-physician Board of Directors determines and supervises the activities of ISMIS, and experienced insurance personnel are retained to carry out physician directives.

The Exchange maintains strict underwriting guidelines for issuing coverage. Any questionable risk is examined by a panel of physicians who review the facts and make decisions regarding insurability and premium costs. Physicians who are refused coverage or who disagree with their classifications may appeal the panel's decision.

Another area in which physician ownership plays a role is in the decision on whether to defend or settle claims. When a claim is filed against a policyholder, physicians review the facts and decide whether to defend the claim or attempt a settlement. The policyholder is kept fully informed on the status of the claim and participates in the decision.

Because the Exchange is owned and operated by physicians, it is particularly sensitive to the needs of its policyholders. An "ISMIE Network" provides physicians with local physician representatives who can help existing and potential policyholders with specific problems. Most Network representatives serve their colleagues in the hospital setting, but they also are often present in large clinics and at meetings of specialty and county medical societies.

The Exchange also maintains a toll-free telephone number (1-800-782-ISMS) for use by physicians outside the 312 calling area.

Another important aspect is the Exchange's commitment to improving the professional liability climate in Illinois. The Exchange played a major role in ISMS' recent initiative for malpractice reform legislation. That initiative brought together countless ISMS members and Exchange policyholders, who formed "action teams" in their local hospitals and county medical societies to orchestrate the massive effort for legislative reform.

Other Programs

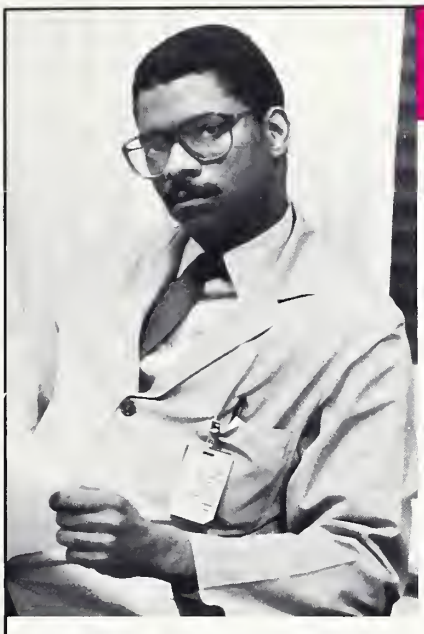
While malpractice insurance is obviously a primary concern of physicians, ISMS also offers a variety of other insurance benefits to its mem-

bers. The Society works with an independent broker to offer a host of programs designed to protect the physician and his or her practice.

- Group term life insurance offers up to $1 million in level term life insurance for ISMS members, their spouses, and their employees.
- A group disability income protection program pays up to $3,000 a month for total disability.
- A professional overhead expense plan provides up to $5,000 a month in office expenses.
- Group major medical coverage pays up to a lifetime maximum of $500,000 on health benefits with a maximum out-of-pocket expense of $4,000 plus deductible.
- Medicare supplemental insurance is available to members and their spouses aged 65 and over.
- A hospital indemnity plan pays benefits of up to $165 per day of hospital confinement regardless of other insurance coverage.

Other insurance programs offered to ISMS members include a workers' compensation program and an accidental death and dismemberment plan.

Information about all insurance benefits is available from the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602, (312) 782-1654.



"A Responsibility as a Citizen and a Right As a Taxpayer"

As a young urologist practicing on Chicago's south side, Dr. Terry Mason felt he had only one choice: get active in organized medicine's fight for liability reform or leave the state.

"There's no question that had there not been some indication of relief, young physicians would have felt the need to leave the state," he says. Dr. Mason, who began his practice in 1983, says he would have been one of those forced to leave.

"I'm one of those people who believe that if you're not working toward solving a problem, you're part of the problem," says Dr. Mason. He adds that many physicians are quick to say their medical societies are not doing enough to confront problems. But when you ask for their personal involvement, you often see "a mass dissipation of energy." The attitude seems to be one of, "I pay my dues for someone else to do that," says Dr. Mason.

During ISMS' professional liability initiative, Dr. Mason took time out from his practice to travel to Springfield for a series of one-on-one meetings with his local legislators. As president of the Cook County Physicians Association, he was instrumental in organizing meetings between area legislators and the CCPA. And he worked to encourage colleagues to join the May 22 Springfield rally organized by ISMS to demonstrate physician concern over the malpractice problem.

Dr. Mason says he believes that he had "a responsibility as a citizen and a right as a taxpayer" to make his views on malpractice known to legislators. He says there is "no question that we did some good" in Springfield. Citing passage of malpractice reform legislation directly after the capitol rally, Dr. Mason says, "if nothing else, we showed doctors that we could make a difference."

He is hopeful that, through their continued involvement, physicians will retain the initiative gained last spring and will continue to fight for additional legislative reforms. As part of his own commitment to stay involved, he recently became a member of the ISMS Council on Governmental Affairs, which examines legislative issues for the Society.

Maintaining that his medical training did "absolutely nothing" to prepare him for the malpractice problem and other critical issues he now faces as a practicing physician, Dr. Mason suggests adjustments in the medical curriculum. He argues that medical education should address the entire scope of the malpractice problem. He feels that medical students must be made aware of how the threat of malpractice relates to medical practice, how it affects what the physician says to patients, and how the physician should conduct himself.

Dr. Mason also suggests that medical training address the increasing influence of corporate entities in medical care. He advocates exposing students to economic aspects of medical practice, such as tax responsibilities and how to evaluate and negotiate contracts with PPOs and other entities.

A Long Way from the Root Cellar

This missive from our itinerant critic came in a few months back, when we had just begun to plan for this special issue on membership. Once again, he's hit the nail on the head—so we saved it to publish this month as we focus on what the medical society is and does for its members and their patients.

Dear Editor:

Rapheal joined the 10 o'clock coffee round table this morning in a very disgruntled mood. That made it unanimous, since everyone else became disgruntled with Raphe's arrival too. Raphe is a hog farmer and has a very definite air about him!

"Cost of vaccine has jumped up again," Raphe growled, "and them antibiotics too!!"

Asa is usually a man of few words, and they usually come "in conclusion" after most of the saying has been said. This time, however, he jumped right in. Probably because he knew he was going to jump right out of the Apollo in search of clean air. "Raphe, you got a head like a brass door knob! Shiny, hard, anyone can turn it, and absolutely no remembrance! Before that vaccine and the antibiotics, you had rhinitis, scours, and dead pigs. . . . How much did that cost you?"

And with that he put his nose in the air—hopefully—and cruised out into the fresh air of Main Street.

The other regulars, recognizing a righteous conversational theme, joined in. "Yep, I can remember Gramma talking about the root cellar, the ice house and salt meat. Now we've got refrigeration and other ways to preserve and keep foods safely," offered Chic.

It caused me to reflect that we all too frequently forget how bad things were, and would still be, if someone hadn't made a change or an improvement. If that hadn't happened, we would still be looking into root cellars!

Apparently Doc Frank must have been entertaining some parallel reflections, because he added some thoughts. "Like Raphe, I sometimes wonder about the cost of some of the things that I do and some of the organizations I belong to. Where would I be—where would all of us be, for that matter—if these organizations just never happened or didn't exist?

"With children's welfare in mind, the State Medical Society supported immunization for school kids, worked for seat belt legislation, and sponsored programs on child abuse.

"Education for the public, and that includes all of us, is probably the most important long term thing that the Society does, and that's as much of an immunization, a way to prevent problems in the future, as we can get."

Well there surely is all kinds of learning, and I'm sure you docs spend a good bit of time learning from each other how to better take care of all of us patients. I was really pleased to have Doc point out how you teach all of us to take better care of ourselves. Setting standards—supporting legislation that will keep us on the right track. . . . I knew all of this. I, after all, do read your magazine. But if I needed to be reminded, perhaps you need to look back from time to time to see where we would be without these changes that you have caused to happen.

And I must congratulate you on all of the educational things you do for us, the public. You've taken us a long way from the root celler.



Your obd. servant,
E. Goodwins

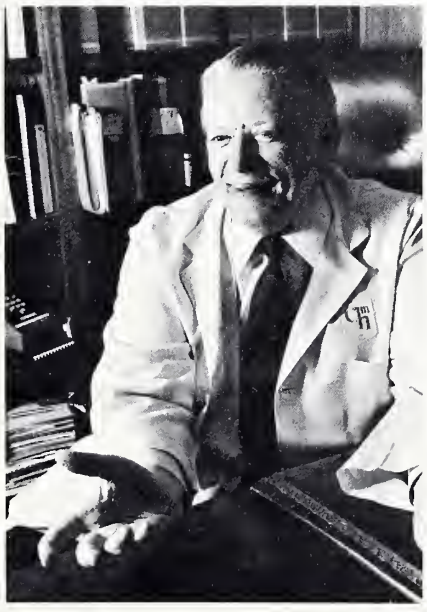
Health Care Economics Examined

Let the Marketplace Decide

John J. Ring, M.D., Mundelein, a board certified family practitioner, is a member of the AMA Board of Trustees. A former member of the ISMS Board of Trustees representing the first district, Dr. Ring was an Illinois delegate to the AMA for many years and is a former chairman of the AMA Council on Medical Service. He now serves the AMA as a member of the Executive Committee of the Board of Trustees, a director of the American Medical Association Education and Research Foundation and a commissioner of the Joint Commission on Accreditation of Hospitals. We asked Dr. Ring to lend us the benefit of his expertise and national perspective in health care economics for this special issue of IMJ.

IMJ: *The 1985 report of the AMA Council on Long Range Planning and Development focuses on the growing dynamism in the environment of medicine. The report finds that medical issues are increasingly tied to other social issues. Patients expect more from what is perceived to be unlimited resources. Where does the physician belong in all of this?*

Dr. Ring: The physician belongs primarily where he was trained to belong and that is at the bedside of the patient. But he also has to realize that we have gone through phases in the medical profession.



When I went to medical school, we were going through a phase where quality of care was the most important thing and price was no object. In the 60s and very early 70s, access to care became the important issue. Every person, regardless of ability to pay, had to have access to very high quality health care. Now we've reached a new phase, where the most important thing is the cost of that care.

The physician at the bedside of his patient has to realize that he is not practicing medicine in a vacuum. He's practicing in a system, and that system is being impacted and altered by cost considerations. He must be responsible with regard to his practice options. He can't order unnecessary tests. It's unethical to recommend unnecessary surgery. He has to have an eye both to the quality of the care and the cost of that care, regardless of who's paying for it.

IMJ: *How can physicians be effective advocates of quality care in a competitive environment?*

Dr. Ring: The first thing the physician has to realize is that he or she has primary responsibility for the quality of care. The hospital administrator is up to his armpits in financial problems. HMOs, PPOs, and the whole alphabet soup of alternative delivery systems, are not designed to improve quality of care. They're designed to deliver care at less cost. The physician, who has an ethical responsibility to his patient, is the person who has primary responsibility for quality of care. And when he sees quality adversely impacted to an unacceptable degree, the physician has to speak up—be it to the HMO, to the hospital, or to whatever delivery modality it might be. It's an ethical obligation to his or her patients.

IMJ: *Let's talk about the health care alphabet. What's your prognostication on the viability of PPOs?*

Dr. Ring: The jury's definitely out on PPO cost savings. We don't have enough information to know if they save money.

IMJ: *How can physicians forming a regional IPA ensure that quality issues will have priority in their organization?*

Dr. Ring: Physicians should ensure that the structure of the IPA gives them sufficient input into the decision making. If an HMO saves money, it does so by keeping patients out of the hospital. It's the only way they save money. If it's a physician-owned HMO, and the policy decisions are being made by the physicians, quality considerations will come to the fore. If physicians don't have significant input, it's much more likely that business considerations will predominate.

Establishing an IPA model HMO is a complex process. An HMO is actually an insurance company. It has to get state approval for its operation, it has to be adequately funded, and it has to be well managed. It has to meet its goals—the goals that it sets for itself.

IMJ: *We now have more than a year's experience with DRGs. What's being done to monitor their progress? What's your opinion about them?*

Dr. Ring: The AMA has a formal DRG monitoring project ongoing. Like so many other people, we're concerned with adverse impact on quality of care by the DRG reimbursement system. The AMA's initial position on the application of DRGs to the Medicare spectrum across the country was opposition. We felt that they should be tested in certain defined regions first. But it was the will of the Congress to apply it nationwide posthaste.

IMJ: *How do you think they work in theory and in practice?*

Dr. Ring: In theory, they work beautifully. In practice, I'm not so sure how they work. I do know from experience with my local hospital and from what I hear that many hospitals are not doing badly financially under DRG. Of course, many physicians didn't do badly under Medicare for the first year or two. But if you ask a group of physicians now how well satisfied they are with Medicare reimbursement, you'll see very few hands go up in the audience. And I would predict that DRG reimbursement to hospitals will be ratcheted down to the point of great discomfort for hospitals.

The physician at the bedside of his patient has to realize that he is not practicing medicine in a vacuum.

It's an artificial, arbitrary mechanism. What they say is, "We'll pay so much for this diagnosis." And if the patient happens to develop another diagnosis while he's in the hospital, and that second disorder keeps him in the hospital for eight to ten months, it doesn't make any difference. Reimbursement is based on the first DRG. Theoretically, it averages out, but in the real world, there are hospitals out there which are going to get hurt.

IMJ: *It's been said that the fee-for-service system as we know it cannot survive. What hybrid do you envision 20 years from now?*

Dr. Ring: First, of all, I don't believe that. And secondly, I don't necessarily envision a hybrid. I think that we'll have fee-for-service 20 years from now. There may be alternative systems and they may have 50, 60 or 70 percent of the market, but I would predict that there will still be fee-for-service medicine. Some physicians may employ fee-for-service, capitation and salaried practice modes simultaneously.

IMJ: *Do you think the proliferation of alternative systems is healthy?*

Dr. Ring: From an economic standpoint, yes, I do.

IMJ: *As a former chairman of the AMA Council on Medical Service, what's your impression of the AMA's direction in this area?*

Dr. Ring: I think AMA policy is quite clear on alternative delivery systems, which are some of the avenues for departure from fee-for-service. We feel that the alternative systems should be tested in the marketplace and given the opportunity to demonstrate their effectiveness, both with regard to cost containment and to impact on quality or access. Then let the American people decide.

The success of an alternative system should be determined by the number of people who prefer that kind of system. And not by government subsidy or government free advertising, or government stimulation of Medicare patients to move into a particular setting. If an alternative delivery system is offered to Medicare patients and they opt for it, the AMA is certainly not going to stand in their way. It believes that these alternative systems should be tested in the marketplace and the patient flow will demonstrate whether they're effective or not.

IMJ: *Do you feel that the alternative delivery systems are in some sense determining reimbursement levels?*

Dr. Ring: On Medicare, I don't think so. Reimbursement levels on Medicare are determined by Medicare. Reimbursement levels of insurance companies are determined by insurance companies. But the billing practices of doctors

aren't governed by that, except in the state of Massachusetts, where it is now illegal to balance bill a patient for the rest of your usual and customary fees. In Massachusetts, if the Medicare payment is $7 less than your usual and customary fee for a service to a patient, and you bill that patient for the $7, you're in violation of the law now. It's a very dangerous precedent. In Massachusetts, a physician—as a condition of licensure—is forbidden to balance bill a patient. The AMA is strongly opposed to this Massachusetts law and supports the state society's efforts to overturn it.

IMJ: *You lose your license for balance billing?*

Dr Ring: You lose your license to practice medicine. You cannot contract with a patient for more than his insurance company will pay. You could be the greatest surgeon in the world, and somebody could come in to you with an extremely complex surgical problem, and your fee for this service might be $1100, but his insurance would pay only $800. You couldn't contract with him for your fee.

IMJ: *How can the medical society help the physician as he learns to interact with these new delivery systems and payment mechanisms?*

Dr. Ring: That a big issue. On the local level, the county medical society provides a forum for the profession where they can meet and discuss problems. It can also provide a forum to bring lots of different factions together. And to give people a chance to talk about things. There is nothing that will increase the attendance at a medical society meeting like a threat.

On the state level, certainly, there is more sophisticated scientific information and contract review and that type of service. I think that what the Illinois State Medical Society has done in contract review is a great service to its members. It's a legitimate function of a medical society to inform its members of the practical effects of signing a contract. The

ISMS Office of Contractual Services

As a result of the move toward Preferred Provider Organizations (PPOs)* and other alternative delivery mechanisms, increasing numbers of physicians are being solicited to sign participating or consulting physician agreements or contracts. Some physicians have contemplated forming PPOs among themselves or as joint ventures with hospitals.

Physicians may unknowingly subject themselves to substantial risk by entering into PPO contracts. For example, some terms of PPO contracts may unnecessarily impose new obligations and liabilities that can alter or inhibit a physician's ability to exercise independent medical judgment in rendering care. Many of the same contractual issues arise in agreements between physicians and Health Maintenance Organizations (HMOs) and Independent Practice Associations (IPAs).

The Illinois State Medical Society has created a special Office of Contractual Services to assist members who are thinking about joining a PPO, HMO, or IPA. The office has retained attorneys to prepare understandable summaries of the terms of proposed PPO, HMO, or IPA contracts.

In addition to reviewing contracts for general legal considerations, the office will focus on the potential effect of a contract on professional liability insurance obtained through the Illinois State Medical Inter-Insurance Exchange. Physicians who are insured with other carriers are advised to provide their carrier with a copy of the proposed contract to determine its potential effect on their liability coverage.

The ISMS office also retains a file of all contracts for which summaries already have been prepared, which allows for more rapid response to member requests for information.

Preparation of the summaries does not constitute legal advice, nor is a summary intended to be a substitute for a thorough reading of the proposed contract. The Office of Contractual Services also cannot counsel a society member as to whether he or she should sign any particular contract. That is a decision left to the judgment of the individual physician.

**It should be noted that the term "Preferred Provider Organization" may be wrongly interpreted by the public to denote quality rather than economic concerns. In considering this issue, the ISMS House of Delegates believes that the term "contract provider organization" may more appropriately identify those physicians who enter into various alternative delivery system contracts. ISMS will continue to advise concerned parties when appropriate that physicians who are "preferred" because of economic agreements do not necessarily provide more quality care than those physicians who choose not to enter "preferred" agreements.*

typical doctor, not having expertise in contract review, either has to hire a lawyer—who might not be expert in contract review either—or try to read and understand the contract himself. I think that this is a tremendous service for the membership.

That's one example of what organized medicine does for its members. There are many others. The state medical society also represents its members to the public. The doctor doesn't have time to go out and be his own PR man. His job is to be a good doctor, and that's his best PR. The medical society's responsibilities are to set ethical standards of professional behavior and to assist in establishing standards of medical education.

Those are also primary functions of the AMA—representation of the profession to the public, to the Congress and to the press. Dissemination of scientific information—the AMA is the largest medical publisher in the world. The association sets ethical standards and standards of professional behavior and assists in setting educational standards for the profession.

IMJ: *Do you think that people will pay to get the best health care available, regardless of what it will cost them?*

Dr. Ring: I think some people will pay and some won't. I think that the central problem is excessive inflation in expenditures for health care.

Let me tell you what I mean by that. In 1984, the percentage increase in health care expenditures dropped from about 11% to about 9%. This was hailed as a great triumph of cost containment efforts on the part of government and payors and the profession and everybody else. Personally, I'm not so enthusiastic. At a time of 4% inflation in the general economy, health care expenditures inflated at a rate of 9-10%—more than twice the general inflation rate. This can't go on.

In recent years, inflation in health expenditures has consistently exceeded the general inflation rate. Excessive inflation in expenditures for health care eventually will drive up the percent of gross national product expended on health care to a point that is intolerable to society. Now some economists have said that 17% might be tolerable. But I don't think that even they would say that 20%-25% would be tolerable, when England is paying 5% of GNP for health care.

It's my belief that the excessive inflation in expenditures for health care is caused by what economists call market failure. In other words, the seller and the buyer of health care services meet in the health care marketplace—a marketplace so distorted by insurance and government health programs, that it isn't like a transaction out in the general, normal economy.



The problem with health care is that it is perceived as cheap or free by far too many people. And the extent to which the responsibility for health care expenditure is placed on those who receive the care will be the extent to which we'll tend toward a restoration of normal market forces in the health care marketplace. And thereby, we could effect a reduction in the rate of inflation of expenditures for health care.

In the mid 1970s, the AMA convened the National Commission on the Cost of Medical Care. The commission was made up of people from all walks of life—the medical profession, the dental profession, hospital administrators, government, consumers, labor people, insurance people. They came up with a report that was actually a blueprint for what is happening now in the health care marketplace. And that is a restoration of market forces, rather than regulation, as the mechanism to dampen the inflationary trend in health expenses.

There are two ways to control runaway inflation—effective regulation or effective competition. Effective regulation would be intolerable.

Effective competition would involve restoration of natural economic forces in the health care marketplace. And that's what is happening now. Everybody is so upset about what's going on—these things are all strange to us. But what's happening now is just what was outlined in the national commission report. It has evolved. It's not happening under the direction of the American Medical Association. It's happening under the direction of the people who are paying the bills for health care. And it is the way to go, unless you want effective regulation to be the mechanism to bring health care expenditure increases in line with expenditure increases in other parts of the economy.

The success of an alternative system should be determined by the number of people who prefer that kind of system.

People say, "What difference does it make if we increase expenditures or the percentage of GNP on health care?" It makes this difference. Every percent of GNP that is expended on health care is a percent that's not expended on something else in the economy. Now if it's tobacco or booze or drugs, I wouldn't give a hoot. But if it's education, if it's housing, if it's food, I would give a hoot. And the current resident in the White House would give a hoot if it's for defense.

It's my belief that the excessive inflation in expenditures for health care is caused by what economists call market failure.

IMJ: *The Council on Medical Service submitted a report to the AMA Interim House which asserted that medicine must take a flexible posture in preadmission review and second surgical opinion programs in order to monitor them effectively. The AMA House made positive comment on the report, but did not adopt it outright, referring it instead for further study. Do you think that preadmission review and second surgical opinion will be tenets of medicine as we know it in the year 2000?*

Dr. Ring: No, I don't believe so. I believe they'll be tried and demonstrated ineffective.

The jury is still out on second surgical opinion. The second surgical opinion programs may actually cost more than they save.

I was talking recently with an insurance executive and mentioned this to him. He said, "That's true, but our accounts want it. The people who are buying the insurance want second surgical opinions, whether they're effective or not. They think it's effective, or potentially effective, so they want to go to second surgical opinion. So we will write a program like that for them." The marketplace will continue to provide it as long as the market demands it. Preadmission review is also an expensive process which could cost more than it saves.

IMJ: *The public is exposed daily to stories about people requiring transplants, dialysis, and other high-cost, high-tech services. Who do you think will be the final arbiter in defining access to those services for the medically indigent?*

Dr. Ring: Decisions to finance the very, very expensive procedures in health care ultimately will be societal in nature.

In England they've made that decision with regard to all health care. England apparently spends about half the percentage of gross national product on health care that we do. Their mortality rates are similar. Their discomfort rate is certainly a lot higher. Their society has opted for a socialized, bare bones medical program. If you're over 55 in England and your kidneys fail, you don't get dialysis. If you have a hernia in England, you could wait three to five years to get it repaired. If you need a hip replacement in England, the chances are fairly high that you'll be dead before the hip gets replaced.

One method to ration health care is to queue it—to require that people sign up on a waiting list for care. England has made a conscious societal decision to go ahead with this type of care. I doubt very much that the American people would sit still for that.

IMJ: *Do you think that Britain will continue to maintain that system?*

Dr. Ring: Yes. I don't think that Margaret Thatcher, despite her conservative outlook on denationalizing industries in England, would think of abolishing the British national health system.

IMJ: *AM News recently reported results of a George Washington University study which found 15% of the under 65 population to be uninsured. Society absorbs the cost one way or another for those who have inadequate coverage. How do you think this should be addressed?*

Dr. Ring: The Council on Medical Service has recommended an expansion of state risk pooling programs to cover a significant portion of the presently uninsured, and has suggested a number of additional approaches that merit further study, including individual catastrophic coverage and mandatory employer-provided insurance. I would have no problem with any of these options or any combination.

You have to realize that a lot of uninsured people aren't really premium indigent. They are voluntarily not insured. They were identified by Luann Aday and other researchers at the University of Chicago in the 1970s. Interestingly enough, the largest proportion of noninsured persons at that time were those involved in a private business

The problem with health care is that it is perceived as cheap or free by far too many people.

of low status who did not have access to employer-provided insurance and who voluntarily chose not to insure themselves.

There's a more recent federal report called, "Who Are the Uninsured?" that shows that a large percentage of the self-employed population in 1984 was uninsured. They own their own business and are voluntarily uninsured. A typical example might be a cess pool pumper who decides that he is young and healthy and he has a young, healthy wife and a young, healthy baby and he decides not to pay for insurance. I think that ought to be outlawed.

IMJ: *How would you describe the future of the Medicare program?*

Dr. Ring: The future of the Medicare program is a bit grim. Somewhere between the late 1980s and the early 21st century, the Part A part of Medicare—the hospitalization insurance—is going to go bankrupt unless changes are made. And changes will have to be made in the Medicare program in order to make it financially viable. It is possible that those changes will include decreased benefits, increased payments, and possibly increased taxes. The tax burden of the Medicare program is already quite burdensome to the folks who are doing the paying. And the folks who are doing the paying are the employed population of the country paying Social Security taxes.

When the Medicare program was founded, five-and-a-half workers supplied hospitalization for each beneficiary. Now, between three and three-and-a-half workers provide hospitalization. That means that you and I and one-and-a-half other people are splitting the bill for one person's hospitalization insurance. Sometime in the next century, it's going to be two workers splitting the bill for each beneficiary. Now, can you see two people who are pumping gasoline at a gas station paying the hospitalization insurance for me? Or somebody else who could afford it himself?

The function of government is to care for those who cannot care for themselves. It's not to provide free hospitalization to somebody with $3 million in the bank.

It's been pretty well demonstrated that a large number of folks over 65 have considerable in the way of assets. I've seen figures suggesting that one third of the people over 65 in this country have assets in excess of $100,000. Is it fair to have three-and-a-half workers paying hospitalization insurance for a person who has assets in excess of $100,000? Just the interest on that $100,000 would pay for the premium.

IMJ: *So you're talking about a totally new interpretation of the Medicare program.*

Dr. Ring: I'm talking my own belief, and that is that the Medicare program possibly will become what it should have been in the first place. And that's a welfare program for people over the age of 65 who are no longer working and no longer able to care for themselves.

The function of government is to care for those who cannot care for themselves. It's not to provide free hospitalization to somebody with $3 million in the bank.

IMJ: *The eighties have brought lowered financial expectations, increased malpractice premiums and liability, lessened scholarship funds and relief of the physician supply crunch. These could be deterrents to medical careers. Do you think that we will again face a major physician shortage when the pendulum swings back?*

Dr. Ring: No, I don't think the pendulum will swing back. I still think that medicine is an attractive profession to a lot of people. There may be some economic disincentives down the road. But I think that there are enough people out there who are anxious to help their fellow man to provide us with enough doctors for the forseeable future. After all, it's the greatest profession in the world.

Is Your Check in the Mail?

By George T. Wilkins, Jr., M.D., chairman, IMPAC

I'm referring to your 1986 contribution to IMPAC, the political action committee of the Illinois State Medical Society.

This is the 26th year that physicians and auxilians have supported medicine's involvement in the political process through IMPAC participation.

The results of this year's primary and general elections will be of great importance to the medical community in Illinois. Lawmakers elected this year are likely to consider proposals to set caps on awards for non-economic losses in malpractice cases. In addition, they will consider PPO legislation and bills concerning medical services contracting. The candidates elected will be decision makers on legislation of great importance to medicine.

These issues are important to each of us. Your support, and that of other IMPAC members, helps to elect legislators who are willing to consider legislation intended to improve the health care environment. This benefits the medical community and, more important, it protects the welfare of our patients.

Medicine is fortunate to have many friends in both Springfield and Washington. They need your support if they are to remain in public office. Remember, many legislators strongly supported our successful effort for tort reform in 1985. This year, many of our supporters have been targeted for defeat by those groups which opposed our efforts. These legislators need and deserve our help.

There are many open seats in the General Assembly. Medicine has the opportunity to assist candidates and make new friends to add to our political strength. There are also opportunities to defeat legislators whose views are in direct opposition to those of the medical community.

It is crucial that physicians and auxilians make their contributions early, in order to enable IMPAC to participate fully in these elections. I urge you to make your personal commitment to medicine's success in the 1986 election by joining IMPAC today.

Suggested IMPAC contributions begin at $45.00 for physicians and $20.00 for auxilians. A contribution of $150 will enroll you as IMPAC Super Sustainer. Super Sustainers will receive a Super Sustaining pin indicating total commitment to medical involvement in the political process.

Your support is essential. Please join IMPAC now. Write your check today. Send your contribution to IMPAC, Twenty North Michigan Ave., Suite 700, Chicago, Illinois 60602.

Yes, Dr. Wilkins, I wish to invest in the future of medicine! Enclosed is my check in the amount of $45.00 (physician) $20.00 (auxilian) $150 (super sustainer)

Name: _____

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State & Zip: _____

Hospital Affiliation: _____

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amount of or failure to make a PAC contribution. Contributions are subject to the limitations of FEC regulations. Section 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are filed with the State Board of Elections and are or will be available for purchase from the State Board of Elections, 1020 South Spring St., Springfield, Illinois, 62704. Contributions from other than members of ISMS and their immediate families are prohibited and will be immediately returned.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:
Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MONMOUTH:
Internist or family practitioner to join a practice in a small town. Terms negotiable. Please send curriculum to P.O. Box 183, Monmouth 61462. (12)

Convention Handbook

Annual Meeting '86

April 4-6
Westin O'Hare Hotel
6100 River Road
Rosemont, Illinois

Members of the House of Delegates
Delegates and Alternate Delegates to the Illinois State Medical Society
Program Summary By Days
Agenda of the House of Delegates
ISMS Delegation to the American Medical Association
Committees of the House of Delegates
Resolutions
ISMS Auxiliary Convention Program

CALLS WILL REACH YOU EASILY
AT CONVENTION '86

Doctor, please inform your staff that while you are attending the ISMS annual meeting, you may be reached through the ISMS Physician's Message Center from 9 a.m. to 4 p.m. Friday and Saturday and on Sunday until noon at this number:

1-312-698-6000

The Illinois State Medical Society
cordially invites you
to the President's Night Dinner

April 4, 1986

honoring

Morgan M. Meyer, M.D.
President
Illinois State Medical Society

Dinner-Dance

Tickets $30.00 per person

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	County	*Delegates*	*Alternate Delegates*
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		Wayne N. Leimbach	James C. Pritchard
		Francis A. Oslay	William T. Sheehy
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		George Goldstein	Mark N. Hill
		Richard K. Hawkins	Phyllis S. Loeff
		Raza M. Khan	Jim I. McClure
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		Peter L. Vinciguerra	Joseph M. Purpura
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	McHenry	August M. Rossetti	William Tortoriello
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	LaSalle	Richard A. Schmidt	
	Livingston	Homer Parkhill	George Chen
	Marshall-Putnam	Don Gallagher	Joe W. Cannon
	Will-Grundy (4)	Van L. Hicks	Kenneth P. Jesunas
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	Henry-Stark	Hipolito Lopez	Even Kvelland
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	Rock Island (3)	Michael C. Ferdinands	James Bull
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	County	*Delegates*	*Alternate Delegates*
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	Sangamon (5)	Mir-Twofig Arjmand	Donald R. Graham
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		Norman Scheibling	Jane Jackman
		Michael C. Snyder	Adarsh Kumar
		Elvin G. Zook	Donald S. Ross
District #6	Adams	James Sutherland	Peter Dureska
	Greene	Jose Parcon	Ludwig Dech
	Jersey-Calhoun	Edgar N. Gipson	Abbas Assar
	Macoupin	Robert G. England	A.E. Villasenor
	Madison (3)	E. K. DuVivier	Norbert T. Belz
		Melvin J. Freedman	Rosalyn B. Lepley
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	Morgan-Scott	Joseph D. Winterhalter	James W. Veenstra
	Pike	Carlos B. Lara	Ronald L. Johnson
District #7	Bond	Boyd E. McCracken	Marion K. Kaufmann
	Christian	A. N. Cruz	E. Doyle Slifer
	Clay	Alva Naney	Eugene Foss
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	Effingham	Ruben Boyajian	
	Fayette	Vasudev Kachgal	Donald H. Rames
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	Union	Carroll Loomis	
	Wabash	William L. Walling	
	Wayne	Eugene B. Loftin	T.S. Agustsson
	White	Phillip D. Boren	
	Williamson	George B. Murphy	Robert D. Kane
District #10	Monroe	Edilberto F. Maglasang	Chung H. Khan
	Perry	Carl J. Campanella	John Fozard
	Randolph	O. W. Pflasterer	Allan L. Liefer
	St. Clair (4)	Dennis J. Stanczyk	Charles R. Frazer, Jr.
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		Robert C. Wanless	William A. Simmons
		Ronald G. Welch	Terence Klingele
	Washington	Methee Vanadilok	
District #11	DuPage (10)	Anita Balodis	Elias E. Benezra
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		Robert E. Fitzgerald	Sharon J. Pelton
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		William P. Gibbons	
		Morgan M. Meyer	
		Joseph R. O'Donnell	
		Erlo Roth	
		Garth D. Smith	
District #12	Boone	Jon E. Dennis	Renuka P. Bale
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	Ogle	Don E. Hinderliter	Nancy S. Williams
	Stephenson	Ahmed Rasheed	Young C. Chung
	Whiteside	John Hubbard	Shashikant A. Patel
	Winnebago (5)	Robert L. Bertrand	Robert A. Behmer
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		Joseph B. Perez	Ervin O. Hrasky
		Forrest H. Riordan, III	Fredrick C. Kullberg
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Hospital Medical Staff Section		Silvana Menendez	Dennis M. Brown
Medical Student Section		Gail Herman	Lynn Malanfant
Resident Physicians Section		Rockford Yapp III	Mark Ridlen

Cook County Delegates

Delegates

Aaronson, Donald W.
Ahstrom, James P., Jr.
Andelman, Samuel L.
Angulo, Ismael
Armstrong, Claresa M.

Beck, Charles A.
Behar, Robt. A.
Beinar, Peter J.
Bellows, Randall T.
Berg, Max
Bieber, Eric J.
Blankshain, Richard H.
Brant, Julius
Brill, Norman R.
Brislen, Andrew J.
Burke, Edward A.
Burkhead, Howard C.

Carroll, Catherine G.
Casey, Gerald M.
Cermak, Miles
Chodash, Howard B.
Ciskoski, Ronald J.
Coleman, John M.
Compall, Theo. C.
Costanzo, Vincent A., Jr.

Diaz, Alfonso
Diffenbaugh, Willis G.
Dohrmann, George J.

Falloon, Edwin
Fischer, Arthur R.
Fish, Wm. D.
Fitzgibbons, James P.
Flanagan, C. Larkin
Frankel, Jerome J.
Fredrick, Earl E.
Friedell, Morris T.

Gertz, Geo. J.
Gianopoulos, John G.
Goodman, Harold
Green, Martin W.
Gueyikian, Berj

Harwood, Thomas R.
Havdala, Henri S.
Hinkamp, Jos. F.
Hoban, Eugene T.
Hyde, John S.

Iannucci, Thos. M.

John, Thomas
Johnson, M. Anita
Joslyn, A. Everett

Kirschenbaum, M. Barry
Kirschner, Ronald L.
Kniffin, Judith M.

Lagorio, Geo. L.
Lanuius, Greg D.
Libman, Robert H.
Lobraico, Rocco V., Jr.
Locker, Brian K.

Alternate Delegates

Al-Aswad, Basel
Alfano, Jos. E.
Aranha, Gerard V.
Araujo, Julius C.

Baldoza, Maximo B.
Bekerman, Carlos
Bianchin, James T.
Blair, Kenneth M.
Burdick, Allison L.
Byrne, Mitchel P.

Casey Donald E., Jr.
Chavez, Ariel R.
Christensen, Eldis M.
Crisp, Elmer E.
Cucco, Ulisse P.
Curl, Geo. G.

De Leon, Lilia S.
Del Fava, Raymond L.
Di Marco, Eugene R.
Dobbertien, Mark A.

Earles, Lucius C.

Fabian, Sydney
Fallah, Abraham
Farah, Geo. S.
Forkosh, David S.
Friedell, Peter E.

Geline, Richard A.
Gianasi, Chas A.
Gianfrancisco, James A.
Gnade, Gerard R.
Gogan, Wm. T.
Goyal, Arvind K.

Hirschmann, Richard A.
Holt, Linda H.

Ignatoff, Jeffrey M.

Jackson, Robt. F., II
Jensen, Mary Jane S.
Jones, Richard J.
Joshi, Nalinaksha V.

Kalsch, Harry E.
Kowal, Roland A.

Lalmalani, Gopal G.
Lemus, Fraterno
Lubben, Georgia D.
Lucchesi, K. Gregory

McCabe, Mary J.
McCarthy, William D.
Meccia, Donald L.
Meyenberg, John E.
Montero, Jose R.

Delegates

MacNerland, Robt. H.
Malvar, Thomas C.
Mason, John W.
McDade, Wm.
Mostowfi, Kiumars
Muriel, Hugo H.
Murray, Meredith B., Jr.

Nemecek, Raymond W.
Neskodny, Jaroslav F.

O'Sullivan, Donal D.
Okner, Henry B.
Olivar, Adriano S.
Ostrowski, Fabian S.

Pedroso, Aldo F.
Perlman, Jack M.
Perritt, Richard A.
Pochyly, Donald F.

Quinlan, Donald

Rice, Clair M., Jr.
Rothstein, David A.
Rubio, Nunilo

Sagerman, Scott D.
Saulys, Augusta Z.
Saulys, Vacys
Schifano, Joseph
Schimel, Samuel
Schuetz, John N.
Seed, Randolph W.
Shapiro, Maynard I.
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Simon, Arnold
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Tansey, William J.
Tekdogan, Mehmet M.
Tencer, Thomas
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Thampy, Kishore J.
Thompson, James R.
Treister, Michael R.

Ungar, Jacob

Vanecko, Robt. M.
Vega, Jesus G.
Velarde, Hugo R.

Walkowiak, Lydia
Wehrmacher, Wm. H.
Whitney, Jack M.
Williams, Jack

Zurita, Victor M

Alternate Delegates

Moutvic, Richard G.
Mowatt, Oswald
Munoz, Maria I.
Murphy, Danl. J.
Murphy, Jos. L.

Neumann, Helene
Nikurs, Lydia

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Ray, Biswamay
Renga, Dominick S.
Richardson, James M.
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Rodriguez, Alberto E.
Roman, Alan M.
Rowley, Nora E.

Salomon, Luis S.
Sassetti, Richard J.
Schall, Saml. M.
Schwartz, Malcolm
Senno, Aref
Sevilla, Paulino Z.
Sherrick, Jos. C.
Shima, Arthur T.
Shobris, Martin
Siedentop, Karl H.
Silverstein, Gerald
Simon, Marshall U.
Smith, Sharon C.
Souman, Mouhammad
Stevenson, George F.
Strohl, Lee H.
Study, Robt. S.
Supple, Peggy A.
Sutoris, Edward D.

Troyer, Wm. G.
Turow, David D.

Vertuno, Leonard L.

Wallk, Silas
Weiss, John W.
Wigder, Herbert N.

Zelinger, Allan B.
Zitek, Russell W.

Agenda
1986 House of Delegates

Lawrence L. Hirsch, M.D., Speaker/Robert Reardon, M.D., Vice-Speaker

First Session

9:30 a.m. ——— Friday, April 4, 1986 ——— Westin O'Hare Hotel
Grand Ballroom

1. Call to order
   Lawrence L. Hirsch, Speaker
2. Invocation
3. Report of Credentials Committee
4. Report of Committee on Rules and Order of Business
5. Approval of minutes of previous meeting
6. Memorial Service for members deceased since April, 1985, conducted by Ronald G. Welch, Secretary-Treasurer
7. Introduction of special guests
8. Remarks of special guests
9. Reports of ancillary groups
   Mrs. Suzanne Meirink, president, Illinois State Medical Society Auxiliary
   Ehlma Garcia, president, Illinois Society, American Association of Medical Assistants
10. Announcement of team physician awards
11. IMPAC report
    George T. Wilkins, Jr., Chairman
12. Introduction of AMA Delegates and Alternate Delegates
    Morgan M. Meyer, Chairman
13. Report of Chairman, Board of Trustees, Alfred J. Clementi
14. Remarks of Speaker
15. Resolutions and supplementary reports
16. New business and announcements
17. Recess until 9:30 a.m., Saturday, April 5, 1986
    Delegates' Buffet—11:30 a.m.-1:30 p.m.
    Reference Committees—1:30 p.m.

Second Session

9:30 a.m. ——— Saturday, April 5, 1986 ——— Westin O'Hare Hotel
Grand Ballroom

1. Call to order by the Speaker
2. Report of Credentials Committee
3. Presentation of educational awards
   Certificates of appreciation to continuing medical education examiners
4. Presentation of AMA-ERF check to Illinois medical schools
5. Introduction of special guests
6. President's Address
   Morgan M. Meyer
7. Reports of reference committees
   Amendments to Constitution and Bylaws
   Committee A-officers, administration, finances, budgets, medical-legal and governmental affairs
   Committee B-government health programs, including health care finance and economics
   Committee C-education, manpower, clinical medicine, scientific matters and medical services
   Committee D-public relations and miscellaneous business
8. New business and announcements
   Recess until 2:00 p.m.
9. Call to order by the Speaker
10. Reports of reference committees
11. New business
12. Recess until 9:00 a.m., Sunday, April 6, 1986
    IMPAC Sustainer Reception

Third Session

9:00 a.m. ——— Sunday, April 6, 1986 ——— Westin O'Hare Hotel
Grand Ballroom

1. Call to Order by the Speaker
2. Report of Credentials Committee
3. Induction of Jere E. Freidheim, President-elect, into office of President by Morgan M. Meyer
4. Address of President Freidheim
5. Announcements and introduction of guests
6. Reports of Reference Committees
7. Elections

   Report of Nominating Committee

   a. President-Elect (Downstate)
   b. 1st Vice-President (Cook County)
   c. 2nd Vice-President (Downstate)
   d. Secretary-Treasurer
   e. Speaker of the House (Cook County)
   f. Vice-Speaker of the House (Downstate)
   g. Trustee Terms Expiring

District	*Terms Expiring*
Second District	Allan L. Goslin
Third District	James H. Andersen
Third District	Audley F. Connor, Jr.
Third District	Harold L. Jensen
Third District	Pedro A. Poma
Eleventh District	Raymond A. Dieter, Jr.
Twelfth District	Raymond E. Hoffmann

   h. Delegates to AMA to take office January 1, 1987 and serve until December 31, 1988

   Terms Expiring
   Audley F. Connor, Jr., Chicago
   David S. Fox, Chicago
   Henrietta Herbolsheimer, Chicago
   Lawrence L. Hirsch, Northbrook
   Michael L. Nieder, Chicago (resident)
   Joseph R. O'Donnell, Glen Ellyn
   Pedro A. Poma, Melrose Park
   P. John Seward, Rockford
   Fred Z. White, Chillicothe
   George T. Wilkins, Jr., Edwardsville

   Downstate Delegate to serve until December 31, 1988, as the 19th Delegate to the AMA.
   —Allan L. Goslin, Streator

   i. Alternate delegates to the AMA to take office January 1, 1987, and serve until December 31, 1988

   Terms Expiring
   James H. Andersen, Oak Brook
   James DeBord, Peoria
   Manuel Guerrero, Rock Island
   Alfred J. Kiessel, Decatur
   William J. Marshall, Chicago
   Joseph B. Perez, Rockford
   Clifton L. Reeder, Wilmette
   Robert M. Vanecko, Chicago
   Nancy Zamora, Rockford (Student)

   Alternate delegate from Cook County to serve until December 31, 1987, as the 18th Alternate Delegate to the AMA
   —Joan E. Cummings, Hines

   j. Judicial Panel member to take office April 6, 1986 and serve until April, 1991; nominated by ISMS President
   k. Rules and Order of Business Committee to take office April, 1986 and serve until April, 1987
   Five (5) delegates nominated by the Speaker and Vice-Speaker of the House
8. Fixing of per capita dues for 1987
9. Selection of meeting place and time for next meeting
10. Unfinished business
11. New business
12. Adjournment, *Sine Die*

ISMS Delegation to the AMA

Delegation Chairman: Morgan M. Meyer/Secretary: Robert C. Hamilton

Delegates

To Serve from Jan. 1, 1985 to Dec. 31, 1986

(Elected April 8, 1984)

Audley F. Connor, Jr., Chicago
David S. Fox, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Northbrook
Michael L. Nieder, Chicago
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park**
P. John Seward, Rockford
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

To serve from Jan. 1, 1986 to Dec. 31, 1987

(Elected April 27, 1985)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator*
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana

Alternates

To Serve from Jan. 1, 1985 to Dec. 31, 1986

(Elected April 8, 1984)

James H. Andersen, Oak Brook
James DeBord, Peoria
Manuel Guerrero, Moline**
Alfred J. Kiessel, Decatur
William J. Marshall, Chicago***
Joseph B. Perez, Rockford
Clifton L. Reeder, Wilmette
Robert M. Vanecko, Chicago
Nancy Zamora, Rockford

To serve from Jan. 1, 1986 to Dec. 31, 1987

(Elected April 27, 1985)

Randall T. Bellows, Chicago
Albino Bismonte, Gurnee****
Ulrich Danckers, River Forest****
Earl E. Frederick, Jr., Chicago
A. Beaumont Johnson, Elgin
Carlos B. Lara, Pittsfield
Joseph H. Skom, Chicago
Warren D. Tuttle, Harrisburg
Ronald Welch, Belleville

**Elected to 19th position, April 27, 1985*
***Elected to 18th position, April 27, 1985*
****Elected April 27, 1985 to completed unexpired term Jan. 1 to Dec. 31, 1986*
*****Elected April 27, 1985 to complete unexpired term until Dec. 31, 1985.*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, New York
John J. Ring, Mundelein

Notification of Annual IMPAC Meeting

The 1986 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 4, 1986, *immediately following the adjournment of the ISMS House of Delegates.*

11:15 a.m. (approx.),
Westin O'Hare Hotel
Rosemont, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1986 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

Robert D. Dooley, M.D., Hinsdale
Allan L. Goslin, M.D., Streator
Mrs. Alfred (Norma) Kiessel, Decatur
Paul F. Mahon, M.D., Springfield
George T. Mitchell, M.D., Marshall
Harry A. Springer, M.D., Evanston
Patrick R. Staunton, M.D., Park Ridge
Mrs. Alan (Pam) Taylor, Danville
Robert M. Vanecko, M.D., Chicago
George T. Wilkins, Jr., M.D., Edwardsville

Committees of the House of Delegates

Committee on Rules and Order of Business

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Committee on Credentials

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform other such duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

Tellers and Sergeants-At-Arms

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Reference Committee on Amendments to Constitution and Bylaws

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws, matters relating to policy, and peer review concerns.

Reference Committee A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances, budgets, medical-legal matters, and governmental affairs.

Reference Committee B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including cost containment, health care financing and economics.

Reference Committee C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower, clinical medicine, scientific matters and medical services.

Reference Committee D

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations and miscellaneous subjects.

Resolutions
1986 Annual Meeting
ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 3 and, according to provisions of the bylaws, are printed in IMJ by title and subject. Final deadline for resolutions is March 5. At this writing it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

Number	Subject	Submitted by
Memorial	J. Ernest Breed	Harold L. Jensen, Chairman, Cook County Delegation
Memorial	H. Close Hesseltine	Harold L. Jensen, Chairman, Cook County Delegation
Memorial	Stanley E. Ruzich	Harold L. Jensen, Chairman, Cook County Delegation
Memorial	William S. Smith	Harold L. Jensen, Chairman, Cook County Delegation
Memorial	George C. Turner	Harold L. Jensen, Chairman, Cook County Delegation
Memorial	Charles J. Weigel	Harold L. Jensen, Chairman, Cook County Delegation
1(A-86)	Corporal Punishment in Illinois Schools	Eugene Loftin, for the Wayne County Medical Society
2(A-86)	Liability for Forced Hospital Patient Discharge	Edwin Sinaiko, Delegate
3(A-86)	Good Samaritan Act	Harold L. Jensen, Chairman, Cook County Delegation
4(A-86)	Council on Affiliate Societies	Alfred J. Clementi, for the Board of Trustees
5(A-86)	Dues Structure	Alfred J. Clementi, for the Board of Trustees
6(A-86)	ICCME	Alfred J. Clementi, for the Board of Trustees
7(A-86)	Insurance Committee	Alfred J. Clementi, for the Board of Trustees

Number	Subject	Submitted by
8(A-86)	Policy Statement on Governmentally Supported Health Facilities	Alfred J. Clementi, for the Board of Trustees
9(A-86)	Policy Statement on Freedom of Choice	Alfred J. Clementi, for the Board of Trustees
10(A-86)	Public Aid Policy Statement	Alfred J. Clementi, for the Board of Trustees
11(A-86)	Policy on Governmental Health Insurance Program	Alfred J. Clementi, for the Board of Trustees
12(A-86)	Policy on Relationship with Third Party Payors	Alfred J. Clementi, for the Board of Trustees
13(A-86)	Policy Statement on "Nurses—Shortage"	Alfred J. Clementi, for the Board of Trustees
14(A-86)	Application of Input-Output Economics to Health Care	David A. Rothstein, Delegate
15(A-86)	Medical Staff Privileges	Luis E. Cespedes, for the DuPage County Medical Society

YOU'RE INVITED



Breakfast Speaker:
Lee A. Daniels (R-Elmhurst)
Republican Leader
Illinois House of Representatives

To a complimentary Public Affairs Breakfast Saturday, April 5, 1986 7:30 a.m. Westin O'Hare Hotel Rosemont, Illinois

Tickets for the breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For futher information, please contact the Governmental Affairs Division at ISMS offices, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. Telephone (312) 782-1654 or (800) 782-ISMS.

The ISMS Benefit Raffle will be held immediately following the Public Affairs breakfast.

ISMS Auxiliary
58th Annual Meeting
Westin O'Hare Hotel

WEDNESDAY, APRIL 2

Noon	Pin and Gavel Luncheon (Past Presidents Only)
1:00-6:00 p.m.	House of Delegates Registration
2:00 p.m.	Pre-Convention Board of Directors Meeting
7:00 p.m.	Board of Directors Dinner (Guests & Delegates Welcome)
Evening	Auxiliary Hospitality Suite (Guests & Delegates Welcome)

THURSDAY, APRIL 3

7:30 a.m.	House of Delegates Registration
8:00 a.m.	First House of Delegates Session Call to Order and Greetings Opening Ceremonies Reading of Rules Appointment of Reading and Reference Committees Treasurer's Report Reading of Budget President's Report to House of Delegates President-Elect's Report to House of Delegates
9:15 a.m.	Keynote Speaker: Edward R. Annis, M.D., Past President of the American Medical Association
9:45-10:30 a.m.	Media Workshop
10:30 a.m.	Introduction of Resolutions
11:00 a.m.	Reference Committee Hearings Organizational Affairs Health Concerns
Noon	Luncheon Honoring Past and Current County, State and National Auxiliary Presidents (Guests and Delegates Welcome)
1:00 p.m.	Awards Presentations
1:45 p.m.	Nominating Committee Report Nominations and Election Instructions Elections
2:30 p.m.	County Presidents' Reports
3:30 p.m.	Guest Speaker: Ms. Marilyn Benveniste
8:00-10:00 p.m.	Chocolate Lovers Heaven Party (Guests & Delegates Welcome)

FRIDAY, APRIL 4

7:00 a.m.	Reference Committee Reports Available
8:00 a.m.	Second House of Delegates Session Election Results
8:20 a.m.	Guest Speaker: Pat Durham (Mrs. Mylie), AMAA President-Elect
8:50 a.m.	Reference Committee Reports Budget Approval

9:15 a.m.	Workshops
Noon	Installation Luncheon Annual Meeting Adjournment
2:15 p.m.	Board of Directors Photograph
2:30 p.m.	Post-Convention Board of Directors Meeting
7:00 p.m.	ISMS President's Night—Honoring Morgan M. Meyer, M.D.

SATURDAY, APRIL 5

7:30 a.m.	ISMS Public Affairs Breakfast

ISMS Annual Meeting

Program Summary By Days

WEDNESDAY, APRIL 2, 1986

2:00 p.m.	ISMIE Executive Committee Meeting
4:00 p.m.	Annual ISMIE Membership Meeting
5:00 p.m.	ISMIE Board of Governors Meeting

THURSDAY, APRIL 3, 1986

9:00 a.m.	ISMS Board of Trustees Meeting

FRIDAY, APRIL 4, 1986

7:30 a.m.	ISMS Board of Trustees Meeting
7:30 a.m.	Rules and Order of Business Meeting
8:00 a.m.	Registration
8:00 a.m.	CMS Caucus
8:30 a.m.	Meeting of Reference Committee Members
8:30 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:15 a.m.	IMPAC Annual Meeting
11:30 a.m.	District Meetings
11:30 a.m.-1:30 p.m.	Delegates' Buffet
1:30 p.m.	Reference Committees
4:30 p.m.	AMA Delegation Meeting
7:00 p.m.	President's Night

SATURDAY, APRIL 5, 1986

7:30 a.m.	ISMS Board of Trustees Meeting
7:30 a.m.	Public Affairs Breakfast
	ISMS Benefit Raffle
8:00 a.m.	Registration
8:30 a.m.	CMS Caucus
9:00 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:00 a.m.	Medical Student Section Meeting
11:00 a.m.	Resident Physicians Section Meeting
Noon	Fifty Year Club Luncheon
1:00 p.m.	CMS Caucus (if necessary)
1:00 p.m.	ISMIE Network Meeting
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
4:45 p.m.	District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, Caucus
8:30 p.m.	IMPAC Sustainer Reception

SUNDAY, APRIL 6, 1986

7:30 a.m.	ISMS Board of Trustees Meeting
8:00 a.m.	Registration
8:30 a.m.	Credentials Committee
9:00 a.m.	House of Delegates
	Board of Trustees Reorganization Meeting Immediately Following House Adjournment.

ILLINOIS STATE MEDICAL SOCIETY

ILLINOIS STATE MEDICAL SOCIETY AUXILIARY

ENTERTAINMENT

Third Annual Benefit Raffle
for the
Educational and Scientific Foundation's
Medical Student Loan Fund

Grand Prize: Weekend Trip for Two to the Big Apple to See Broadway

Including limo pickup, dinner, tickets to Broadway plays, air fare, and hotel
(subject to availability; other restrictions may apply)

2nd Prize: Drake Hotel Weekend, Chicago

3rd Prize: Westin Hotel Weekend, Chicago

4th Prize: Waterford Crystal Vase

5th Prize: Round of Golf and Dinner for Two at Medinah Country Club

Other prizes to be announced

Drawing Held Saturday, April 5, 1986
Immediately following the Public Affairs Breakfast
at ISMS Annual Meeting

Ticket sheets have been mailed to all
ISMS/ISMSA members

$6.00 per ticket

$50.00 per 10-ticket sheet
Winners need not be present

Contributions to the ISMS Educational and Scientific Foundation are normally tax deductible to the extent allowed by law.

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Endocrinology	Pediatrics
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Flight Surgeon	Pediatric Surgery
General Surgery	Psychiatry
Infectious Disease	Radiology
Internal Medicine	Radiotherapist
Neurology	

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- **C Track** Critical Broadcasting Skills (on air two years)
- **D Track** Media Pros (on air for three years or regular reporting in a major media market)

PROGRAM SCHEDULE:

Thursday, May 1
Optional Seminar
Professional Meeting
Welcome Reception

Friday & Saturday, May 2 & 3
Workshops, Lunch, Fireside Chat
8:00 a.m.-6:00 p.m.

Sunday, May 4
Workshops

Category 1 CME Credit

Optional Professional Day open only to C&D track participants

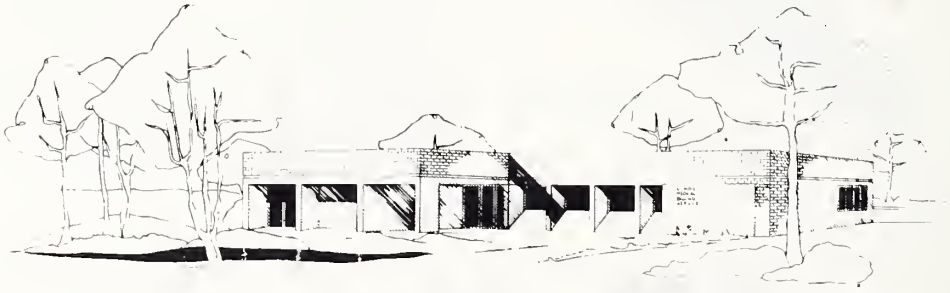
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John Butler
Executive Vice President

EKG

(Continued from page 58)

Answers: 1. A, B, C. 2. E.

The first half of the twelve lead ECG shows a regular tachycardia at a rate of 140 beats per minute .The QRS duration is normal and no P waves can be seen. The RR cycle shortens approximately 40mSec in the last cycle of the leads AVR, AVL, AVF column before the lead change to the $V_1V_2V_3$ column. This is a paroxysmal supraventricular tachycardia. It is most likely caused by reentry in dual atrioventricular (AV) nodal pathways. The often seen shortening or lengthening of the RR cycles before the tachycardia breaks is the result of a change in the refractoriness of the dual AV nodal pathways. In this case, a one second pause occurs and a temporary pacemaker escape beat is seen. The last five beats of the ECG have irregular cycles. This was a return to her baseline atrial fibrillation.

This patient had had rheumatic heart disease years ago and atrial fibrillation had been present for several of these years. In 1971, she had a mitral commissurotomy performed for severe mitral stenosis. Her history and physical examination now suggested a recurrence of the mitral stenosis. The cardiac catheterization demonstrated severe pulmonary hypertension with a systolic pressure of 110mmHg. The mitral valve index calculated $0.5cm^2/m^2$. The coronary arteriogram showed obstructive disease in the left anterior descending and obtuse marginal arteries not present in 1971. Significant tricuspid regurgitation had also developed as a result of the severe pulmonary hypertension secondary to the severe mitral stenosis.

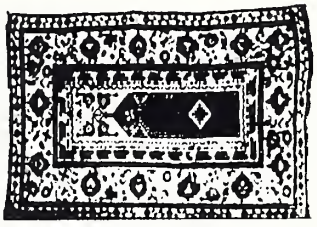
Open heart surgery with a mitral valve replacement and tricuspid plication was performed. A temporary pacing wire was left in place to aid postoperative management of the patient. ECG monitoring revealed the paroxysmal supraventricular tachycardia in addition to the atrial fibrillation. An increased dose of digoxin eliminated the supraventricular tachycardia and controlled the ventricular response to atrial fibrillation. No permanent pacemaker was required. The patient was placed on anticoagulation, discharged home, and has been well to date. ◀

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MARCH

Oncology

Fourth Annual Oncology Symposium
For: Physicians. **Date:** To be determined, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Credit:** Category 1: Hours to be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Otolaryngology

Decisions in Diagnosis and Management of Nasal and Sinus Disease
For: Otolaryngologists. Course, March 23-28, Vail, CO. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** 50. **Credit:** Category 1: 22 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Cardio-Disease/Physics/Medicine

Medical Seminar at Sea (Caribbean Cruise)
For: Physicians. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $400. **Credit:** Category 1: 36 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Neurology

Neurology Symposium
For: Physicians. **Date:** March 21. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Fee:** None. **Credit:** Category 1: 9 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Current Aspects of Seizure Disorders
For: Physicians. Symposium, March 26, 8:00 a.m.-5:00 p.m., Chicago, IL. **Sponsors:** Rush University, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago, IL 60612. **Fee:** $25. **Reg. Limit:** 150. **Credit:** Category 1: 7 hours; **AAFP Elective** (applied for): 7 hours. **Contact:** Barbara Trejo. **Phone:** (312) 942-7095.

Radiology

Specialty Review in Radiology
For: Radiologists. Lecture, March 31-April 4, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 90. **Credit:** Category 1: 48 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Pathology

Current Concepts on Thyroid Tumor Pathology
For Pathologists. March 17, 7:00 p.m., Drake Hotel, Chicago, IL. **Sponsor:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Psychiatry

Comprehensive Psychiatry Review, Part 1
For: Psychiatrists. March 17-22, **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $500. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Mary Ann Dillon. **Phone:** (312) 962-1056.

The Clinical Basis of Psychiatry: A Comprehensive Review and Update
For: Psychiatrists and neurologists. Lecture, March 3-7, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $660. **Reg. Limit:** 90. **Credit:** Category 1: 44 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

General Medicine

Controversies in Medicine
For: Physicians. March 7-9, Chicago Hilton Hotel & Towers, Chicago. **Sponsor:** Chicago Medical Society, 515 N. Dearborn, Chicago, IL 60610. **Fee:** Preregistration fees are as follows: Members-$25., Non-members-$100. On site registration is available. **Reg. Deadline:** February 28. **Reg. Limit:** None. **Credit:** Category 1. **Contact:** William Verick. **Phone:** (312) 670-2550.

Pulmonary Medicine

Symposium on Chronic Obstructive Pulmonary Disease
For: Physicians and allied health personnel. Conference, March 6-7, Madison, WI. **Sponsor:** University of Wisconsin-CME, 465 WARF Bldg, 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 14 hours; University of Wisconsin CEUs: Approx. 14 hrs. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Unique Seminars

The "Leadership" seminar assists the medical leadership in understanding the basic elements of effective CME planning. Participants will gain a foundation of skill in group techniques to involve medical staff members in CME planning and in how to start the systematic effort that leads to effective CME in the hospital setting.

The "Evaluation of CME Process" seminar provides the medical leadership with the practical information to apply the purposes of evaluation to program administration, faculty performance and participant learning. The leadership will discuss various common techniques used in the evaluation process for the development and implementation of quality CME programs.

For further information about participating in a unique ICCME seminar, please contact the Illinois State Medical Society, Twenty North Michigan Avenue, Chicago Illinois 60602 (312-782-1654).

Sports Medicine
Second Annual Sports Medicine Conference
The Amateur Athlete: The Young and Mature
For: Interested physicians. Conference, March 12, 8:00 A.M.-4:00 P.M., Rockford, IL. **Sponsor:** University of Illinois College of Medicine at Rockford, 1601 Parkview Avenue, Rockford, IL 61109. **Fee:** None. **Contact:** Patricia Krusiec. **Phone:** (815) 987-7140.

APRIL

Allergy
The Relationship of Respiratory Infections to Asthma
For: Physicians. Lecture (dinner meeting), April 21, 6:00 p.m., Chicago, IL. **Sponsor:** The Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane K. Kubis. **Phone:** (312) 255-1024.

Ophthalmology
8th Annual Midwest Glaucoma Symposium
For: Ophthalmologists. Symposium, April 11-12, 8:30 a.m.-5:30 p.m., Chicago, IL. **Sponsor:** The University of Illinois College of Medicine at Chicago, Department of Ophthalmology, and Northwestern University. **Fee:** $225 for physicians, $100 for residents. **Reg. Deadline:** March 28. **Reg. Limit:** 250. **Credit:** Category 1: 12 hours. **Contact:** Sue Koricnek, The University of Illinois at Chicago, Conferences and Institutes, 912 S. Wood St., 2N, Chicago, IL 60612. **Phone:** (312) 996-8025.

10th Annual Ophthalmology Current Concepts Seminar '86
For: Ophthalmologists. Conference, April 10-12, Madison, WI. **Sponsors:** University of Wisconsin-Madison, Department of Ophthalmology, and School of Medicine, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: approx. 18 hours; University of Wisconsin CEU's: approx. 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Emergency Medicine
Illinois ACEP 1986 Scientific Assembly
For: Emergency physicians, nurses, paramedics, pediatricians and family practice physicians. April 11-13, The Hamilton Hotel, Itasca, IL. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Fee:** $90-$250. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Advanced Trauma Life Support Provider Course
For: Physicians. Symposium, April 2-3, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Fee:** $350 for physicians and $200 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Neurology/Biology/Basic Sciences
Ninth Annual Midwest Neurobiology Meeting
For: Physicians. Symposium, April 4-6, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** To be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Gynecology
Current Management of Problems in Gynecology and Gynecologic Urology
For: Ob-Gyn's. Course, April 11-12, Knickerbocker Hotel, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $225. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, ACOG: 10 Cognates. **Contact:** Marlene Goldberg, **Phone:** (312) 962-1056.

Office Obstetrical Management: Risks and Benefits
For: Physicians and other health professionals. Conference, April 15-16, Madison, WI. **Sponsors:** University of Wisconsin-Madison-CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705; and departments of OB/GYN, pediatrics and family practice, School of Medicine, University of Wisconsin-Madison; Madison General Hospital. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; University of Wisconsin CEU's: 10 hours; AAFP Prescribed: Credit pending, approx. 10 hours; AOA Category 2-D: credit pending. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pathology
Recent Advances in Hematology
For: Pathologists and hematologists. Symposium, April 14, 7:00 p.m., Drake Hotel, Chicago, IL. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** (members only) Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Avenue, Chicago, IL 60644.

Cleft Lip/Palate
Cleft Lip and Palate: A 1986 Perspective
For: Physicians. Course, April 4-5, 9:00 a.m.-4:00 p.m., Chicago, IL. **Sponsor:** Center for Craniofacial Anomalies, University of Illinois at Chicago, P.O. Box 6998, Chicago, IL 60612. **Fee:** $150 for physicians and $100 residents/students. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marcia Aduss at above address.

Pediatrics/Family Medicine
Contemporary Pediatrics for the Practicing Physician
For: Pediatricians and family physicians. Course, April 18-19, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg, Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, **AAFP Prescribed:** 10 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Internal Medicine/Family Medicine
Aggressive Management of Diabetes and Obesity
For: General internists and family physicians. Course, April 11-12, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 11 hours. **AAFP Prescribed:** 11 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Clinical Endocrinology for 1986
For: Family practitioners. Symposium, April 5, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $60. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

MAY

Allergy
Resident-Fellow Abstact Presentation
For: Allergists. May 19, 6:00 (cocktails), 7:00 (dinner), 8:00 p.m. (meeting), Holiday City Centre, Chicago, IL. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1.5 hours. **Contact:** Dianne K. Kubis. **Phone:** (312) 255-1024.

Psychiatry
The Psychiatric Interview
For: Psychiatrists. Course, May 16-18, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Mary Ann Dillon. **Phone:** (312) 962-1056.

Pediatrics/Neurology
Medical Seminar-at-Sea (Fjords)
For: Physicians. Symposium, May 17-28, British Isles/Ireland/Norway. **Sponsor:** Southern Illinois University School of Medicine, CME, P.O. Box 3926, Springfield, IL 62708. **Fee:** $500. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine
17th Family Medicine Review
For: Family Physicians. Course, May 18-23, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $425 ($450 after 5/2). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP Elective: 50 hours. **Contact:** Rosemary Fisher. **Phone:** (606) 233-5264.

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EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Allison Katz, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

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ARIZONA BASED PHYSICIAN RECRUITMENT firm has opportunities coast to coast. "Professionals working with Professionals." Over 13 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

HEALTHLINE PHYSICIAN SERVICES, An affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency departments, clinics and locum tenums work. Healthline offers excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman at Healthline Physician Services, 8401 Hanley Industrial Court, St. Louis, MO 63144; (314) 962-1233.

FAMILY PRACTICE/Internal Medicine—Central Illinois. Various opportunities available: solo and group. Reply to Box 1186, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

PRIVATE PRACTICE Opportunities: Internal Medicine, family practice- OB/GYN- pediatrics. Guaranteed income-no capital investment. Affiliated with major university. Call (314) 727-2660.

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FAMILY PRACTITIONER needed to join 11 physician, expanding multi-specialty practice in upper Midwest. Board certified or eligible. Clinic adjoins JCAH hospital. Rural location with abundant outdoor recreational opportunities, small 4-year college. Excellent salary and benefits. Call collect (715) 532-6651 or send curriculum vitae with names of references to: Howard Chatterton, M.D., 906 College Avenue West, Ladysmith, WI 54848.

OPHTHALMOLOGIST, ILLINOIS: Locum tenens. Start immediately. High income, high volume general ophthalmology practice. Owner needs help. Assist surgery and patients. Housing available. Possible future career opportunity. Write Box #1191, c/o, *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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ALLERGIST—ABAI certified/eligible via pediatrics or medicine wanted part-time or full-time in suburban Chicago allergy practice (multiple HMO/PPO/private patient mixture). Reply to Box #1196, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CARDIOLOGIST. Excellent opportunity for a board certified or eligible cardiologist to associate with a progressive cardiology group in north central Wisconsin. Modern single community hospital offering all varieties of comprehensive cardiology and cardiovascular/thoracic surgery services. Position available now. If interested, send C.V. to and/or contact D. Joe Freeman, MD, FACC, North Central Heart Clinic, 425 Pine Ridge Blvd., Suite 204, Wausau, Wisconsin 54401; (715) 845-NCHC (6242).

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RHEUMATOLOGY. Lucrative practice opening in association with dynamic growth-oriented 234-bed hospital. Studies of the area document the need for this search which also has the full support of the medical staff. Space has been reserved in the new professional office building adjoining the

completely rebuilt hospital. Competitive financial guarantees and good coverage are available. Quality lifestyle in community of 40,000 within a metropolitan area of 350,000, offers the best of country and city living. Medical school and several colleges within 15 minutes. Immediate access to cultural and outstanding recreational activities. Call (collect) Karlman Associates (415) 775-1657.

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INTERNAL MEDICINE. Lucrative practice opening in association with dynamic growth-oriented 234-bed hospital. Studies of the area document the need for this search which also has the full support of the medical staff. Space has been reserved in the new professional office building adjoining the completely rebuilt hospital. Competitive financial guarantees and good coverage are available. Quality lifestyle in community of 40,000 within a metropolitan area of 350,000, offers the best of country and city living. Medical school and several colleges within 15 minutes. Immediate access to cultural and outstanding recreational activities. Call (collect) Karlman Associates (415) 775-1657.

SITUATIONS WANTED

PGY1-GRADUATE of the University of Alexandria Egypt—speaks English and French fluently. Uncle is a surgeon in Illinois (U.S. citizen), will sponsor me. Seeking residency in any surgical specialty (general, E.N.T., ophthalmology, orthopedics, urology, ob.gyn., dermatology). All requirements will be complied with. Reply to Box 1167, c/o *Illinois Medical Journal*. Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

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HUSBAND-DENTIST/WIFE a family practitioner searching for a place to start their practices either solo or partnership in a town anywhere in Illinois or bordering states preferred. Call: (515) 464-2432.

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INTERNIST SEEKS part or full time position: days, evenings, or nights Chicago metropolitan area. Experienced in occupational/industrial and general practice. University trained. Reply to Box #1198, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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MISCELLANEOUS

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A Challenging and Fulfilling Year



I was pleased to serve as president of the Illinois State Medical Society this year.

My President's Tour took me to 25 county medical societies, one branch society meeting and three other state medical societies. Topics of concern as I talked with my colleagues around the state have included the professional liability crisis, reinsurance, Medicare problems—including DRGs and the fee freeze, and the challenges of our changing health care environment, including alternative delivery systems.

The President's Tour theme this year centered around the physician's role as patient advocate. I urged my colleagues to educate patients, the public and the media on all health care matters both clinical and socioeconomic. I also advocated a strong organized medical community and urged physicians to support our unified membership in the county medical societies, Illinois State Medical Society and American Medical Association. Of course, the strength of organized medicine comes from the grassroots county medical society level. We have seen that principle proven with some fine local hospital action team efforts.

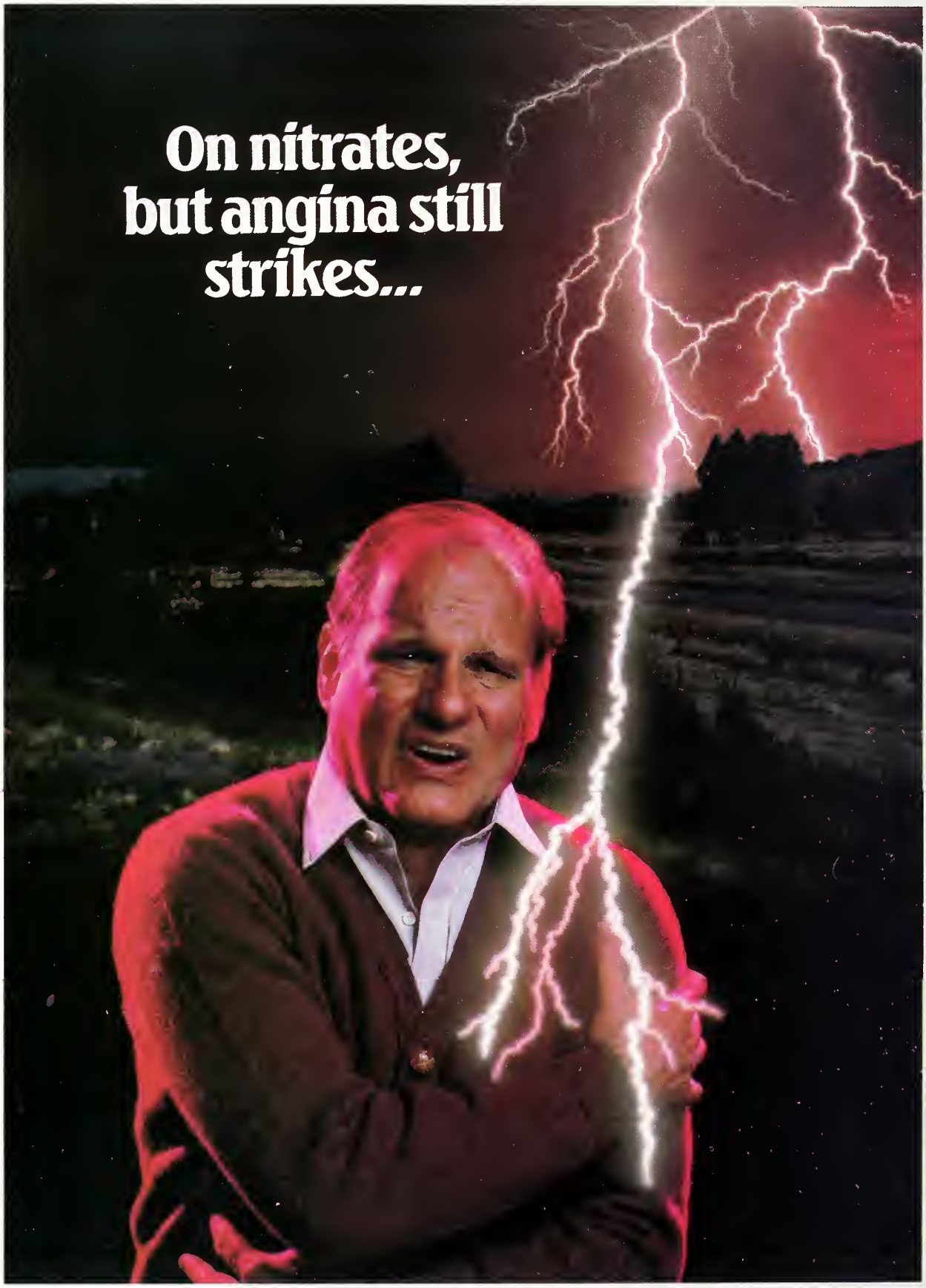
I took office as president in April of 1985, a month before the May 22nd Springfield rally. The day's events unfolded quickly, starting with rousing briefing sessions in the morning and continuing at a hectic pace through the afternoon's last-minute summit meetings of the four legislative leaders and the Governor's aide. It was thrilling to stand on the Capitol steps and hear House Republican Leader Lee Daniels, from my home county of DuPage, announce our legislative success with agreement on 11 of 13 submitted bills. I salute our ISMS staff and Mr. Alexander R. Lerner, our executive administrator, for their vision, planning and execution.

Everywhere on both my president's tour and at home, I talked with representatives of the media, both print and electronic. The subject of most concern was the malpractice crisis, the constitutional challenge in the Circuit Court of Cook County and the Society's response to that challenge. In addition, the media has been interested in other topics, such as the Medicare DRG system, the fee freeze and clinical topics from AIDS to acupuncture. Medical discipline has been a topic of concern from several areas and I was pleased to be named to serve on the task force appointed by Governor James R. Thompson to address this problem.

In addition to my service as president I was pleased to serve as chairman of the Illinois Delegation to the AMA this year. My best wishes go to Dr. Jere Freidheim for the upcoming year. I pledge support and continued effort to help win a more satisfactory solution to tort reform, including "caps" on non-economic damages. ◀

Morgan M. Meyer

Morgan M. Meyer, M.D.
President


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but angina still
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Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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2406

OBITUARIES

****Bard, G.W.I.,** Kankakee, died January 2, 1986 at the age of 76. Dr. Bard was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

***Breslow, Lawrence,** Glencoe, died January 16, 1986 at the age of 74. Dr. Breslow was a 1936 graduate of the Washington University School of Medicine, St. Louis, Missouri.

****Butler, Stuyvesant P.,** Hubbard Woods, died February 3, 1986 at the age of 83. Dr. Butler was a 1929 graduate of Rush Medical College, Chicago.

****Finkle, John R.,** Albuquerque, New Mexico (formerly of Berwyn), died December 1, 1985 at the age of 84. Dr. Finkle was a 1929 graduate of Rush Medical College, Chicago.

***Manelis, Joseph,** Suisun, California, died January 18, 1986 at the age of 50. Dr. Manelis was a 1960 graduate of the University of Illinois College of Medicine, Chicago.

***Owings, Jerry R.,** Lincoln, died December 15, 1985 at the age of 74. Dr. Owings was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Riordan, Gerald T.,** Springfield, died February 1, 1986 at the age of 62. Dr. Riordan was a 1947 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Russell, Roland D.,** Pelzer, South Carolina (formerly of Elgin), died January 14, 1986 at the age of 90. Dr. Russell was a 1916 graduate of the Emory University School of Medicine, Atlanta, Georgia.

****Rydelski, Michael A.,** Chicago, died January 25, 1986 at the age of 89. Dr. Rydelski was a 1923 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Sedlak, Frank C.,** Riverside, died January 18, 1986 at the age of 74. Dr. Sedlak was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

***Smith, William S.,** South Holland, died January 9, 1986 at the age of 61. Dr. Smith was a 1952 graduate of Northwestern University Medical School, Chicago.

****Wallace, James H.,** Longboat Key, Florida (formerly of Oak Park), died January 4, 1986 at the age of 91. Dr. Wallace was a 1918 graduate of Northwestern University Medical School, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Who Should Pay?

Hepatitis B Vaccine for Medical Students

By Howard B. Chodash/ISMS-MSS Alternate Representative, University of Illinois, Chicago

You are drawing a blood sample from a patient who suddenly lurches, causing you to stick yourself with the needle. You later learn that the patient has serum hepatitis. That needle may have transferred some Hepatitis B virus into your system. A few months pass by. You develop hepatitis and may become a carrier of HBv and eventually develop cirrhosis or hepatocellular carcinoma. This is not the best way to end one's career.

Does this scenario seem far fetched? Well it may not be as crazy as it sounds. Several studies have shown that approximately 1.5% of all hospital admissions are positive for HBsAg. Most of these patients are not admitted for hepatitis or other liver diseases and therefore not recognized as carriers right away.[1] These patients pose a major hazard to hospital workers, including medical students. Fortunately, events like these can be prevented by vaccination.

While the vaccine has been around for more than ten years its use is still not widespread. One of the main deterrents for students and others is the cost: the three dose series costs about $100. For this reason, the Medical Student Section asked the AMA last June to encourage financial aid offices at medical schools to establish methods for financing the vaccination. It was recommended that they pursue present avenues as well as investigate medical school liability for failure to provide immunization programs for Hepatitis B. As of the December Interim Meeting, this matter remained under investigation. For those second year students about to enter the hospital, and third and fourth year students who are not immunized and possibly not informed, these issues are important. The answer to the liability question may help determine who will pay for the vaccination.

Many hospitals have programs to inform and immunize their employees for HBv: they realize the importance of providing safe working conditions. Some offer the vaccine at cost; others for free. The University of Tennessee Memorial Research Center and Hospital, after weighing the possible aspects for financing their program, came to the conclusion that for a successful program the hospital should pay for the vaccine.[2] They felt that a successful program would reduce hospital liability. While their program includes students, which is laudable, other hospitals leave students out as non-employees. Although students are not paid, they provide a valuable service for the hospital and should have the same right to safe working conditions.

In the literature, students are often categorized in the moderate risk group in terms of infection by HBv,[3] but AMA now places students in the high risk group. This is partially due to the students' inexperience and their lack of previous exposure to the disease. For the latter reason, students and other entry level employees have a relatively low expected prevalence of HBv markers. According to a study by Mulley, *et. al.*,[4] vaccination of this group is more cost-effective than screening. This is true whether the individual or the institution picks up the cost.

Even when the vaccine is offered free, some persons will decline it. Lack of compliance can decrease the effectiveness of a vaccination program. Individuals give many reasons; fear of possibly harmful side effects from the vaccine is often among them. It is necessary to educate people about the importance of the vaccine, its efficacy, and its safety. The vaccine in use has been given to more than 200,000 people. There are no known immediate,

serious, or long-term reactions.[1] However, in approximately 20%, temporary, minor reactions have been reported such as mild soreness or erythema at the injection site, low grade fever or muscle and joint pain. Concern over the possible transmission of acquired immunodeficiency syndrome (AIDS) lacks supporting evidence.[5] The steps used in the production of the vaccine are reportedly able to inactivate representatives of any known virus groups, including the one that causes AIDS. The fears that people have toward vaccine, to date, are unconfirmed.

One vaccination program which proved relatively effective was that held at the Methodist Medical Center of Peoria, Illinois. Seventy-one percent of those identified at high risk received the first dose. Of those individuals who had the first dose and remained employed at the hospital, 100% received the second dose and 94% completed the three dose series. Fred Z. White, M.D., Chillicothe, reported in the February, 1984, *Illinois Medical Journal* that the success of this program was due, in part, to the support of the medical staff, administration, and, in particular, the department heads and chairs.[6] Not only education of employees, but also support from the hospital staff, are important for compliance and in promoting the program.

Whatever the eventual outcome of the AMA investigation into medical school liability, one should not wait to be vaccinated. For students, the benefits of the vaccination compared to the consequences of developing viral hepatitis outweigh the cost of the vaccine regardless of who pays for it, the student or the schools and hospitals. The slogan, "you could pay now or you could pay later," is very much applicable to this situation. If found to be liable, schools which do not provide a vaccination program could be open to costly negligence suits. On the other hand, students who do not get the vaccine because of the expense, could pay later with their health, career, and even their lives.

References

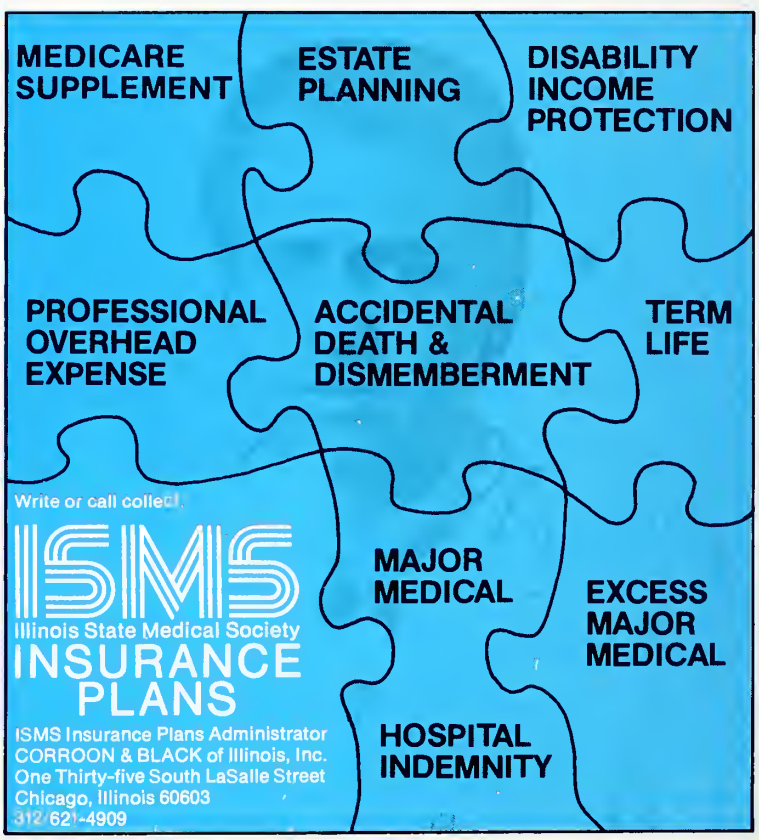
1. Gocke, D.J.: "Immunization Against Hepatitis B," *Advances in Internal Medicine* 29:1-23, 1984.
2. Utt, J.K., Buttler, J.L.: "Financial Aspects of Hepatitis B Vaccination Program," *American Journal of Hospital Pharmacy* 41:874-5, 1984.
3. Hamilton, J.D.: "Hepatitis B. Virus Vaccine: An Analysis of Its Potential Use in Medical Workers," *JAMA* 259: 2145-50, 1983.
4. Mulley, A.G., *et al.*: "Indications for Use of Hepatitis B Vaccine, Based on Cost-Effectiveness Analysis," *New England Journal of Medicine* 307:644-52, 1982.
5. Poiesz, B., *et al.*: "Hepatitis B Vaccine: Evidence Confirming Lack of AIDS Transmission," *Morbidity and Mortality Weekly Report* 33 (49): 1984.
6. White, F.Z.: "Report of a Hepatitis Immunization Program," *Illinois Medical Journal* 165:102-103, 1984.

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Patricia Watkis, M.D., Department of Radiology, Loyola University Medical Center, Maywood

This 13-year-old boy had right hip pain for six months. Tomogram of the hip is shown.



Figure 1
Proximal right femur, tomogram. There is an oval osteolytic lesion straddling growth plate of the femoral head. The lesion is sharply defined and has a thin sclerotic rim.

Your diagnosis?
(1) Enchondroma
(2) Osteochondroma
(3) Chondromyxoid fibroma
(4) Chondroblastoma
(5) Periosteal chondroma

(Continued on page 178)

ABSTRACTS OF ACTIONS

January 25, 1986

ISMS Conference Complex

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Task Force on Discipline

The Board considered a report from legal counsel on model AMA legislation that would amend the Medical Practice Act to allow the Medical Society, at the request of the Medical Disciplinary Board, to review disciplinary complaints, including fee adjudication. Legal counsel included in its proposal the element of physician negotiating as part of the legislation which could be developed. Also included in the proposal is maintenance of confidentiality, anti-trust exemptions, immunity from civil liability for actions performed in disciplinary review when requested by the Medical Disciplinary Board, and the non-discoverability of peer review.

The Board approved legal counsel's proposal for amendatory legislation for the Medical Disciplinary Act which would allow utilization of Medical Society review and fee adjudication, and further agreed that there be authorization for development of legislation for introduction during the current session of the General Assembly, if feasible, and that this proposal be directed to the Task Force on Discipline for further consideration. The Board also directed that this issue be submitted to the AMA Delegation for federal study.

Hospital Mandated Minimal Limits of Insurance

The Board reviewed a report from legal counsel pertaining to a Survey of Hospital Medical Staffs on Minimum Mandatory Levels of Malpractice Insurance.

The Board agreed to survey chiefs of staff of Illinois hospitals to determine the local situation regarding mandated limits of professional liability coverage. The Board further agreed to disseminate only the survey results at this time. Authorization was given to legal counsel to explore the issue of joint and several liability so that the Society can formulate legislation, if appropriate.

Student Clerkships

An amendment to the Hospital Licensing Act has been enacted which denies hospitals the ability to engage medical students in clerkships when such students are enrolled at a medical school not approved by R & E.

The Board agreed to inform presidents of medical staffs of these changes in the Hospital Licensing Act.

Nursing Home Study

The Board reviewed a report from the Council on Medical Services of the physician's role in a nursing home. The Council would like to work with nursing home organizations and the IDPH in surveying long-term care facilities and the physicians that utilize these homes.

The Board agreed, in cooperation with other agencies, to conduct a survey of nursing homes and physicians who treat nursing home patients, in order to study the role of a physician in a nursing home.

Committee on Drugs and Therapeutics

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Betoptic; Proventil Syrup; Tambocor; Inderide-LA; Capozide; Methadone HCL; Ridaura; Generic Betamethasone Valenate; Generic Bethamethasone Dipropionate; and Generic Fluocinolone Acetonide.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Lac-Hydrin; Calderol; Florone; FML Ophthalmic Ointment; Benzamycin; Acetaminophen w/Oxycodone HCL; and Aquatar.

The Board further recommended that Catapres-TTS patches be included in the IDPA Drug Manual.

In addition, the Board reviewed a policy statement entitled, "IDPA Drug Manual," and recommended that no change be made at this time.

Other Actions

In addressing various other issues, the Board:

- Accepted: The Financial Statements for the period ended October 31, 1985; December 31, 1985, IMPAC Collection Data Report; December 31, 1985, Dues Payment Report; and Requests for Changes in Membership Status, with the deletion of Dr. Lloyd A. McCarthy, Barrington, Kane County Medical Society, First District, from Retired Status.
- Approved the 1986 budget as presented.
- Approved three resolutions for introduction to the 1986 House of Delegates entitled, "Council on Affiliate Societies," "ICCME," and "Dues Structure."
- Directed that the Chairman inform the Board of Trustees as to the disposition of placement for the

ISMS Directors and Officers Liability Insurance.
- Approved a resolution for introduction to the 1986 House of Delegates entitled, "Insurance Committee."
- Approved the Policy Committee's work plan for review, revision and update of "Official ISMS Actions."
- Approved an Unfinished Business Report for the 1986 Annual Meeting, pertaining to Directors and Officers Insurance. (Res. 21 A-85)
- Accepted for submission to the 1986 ISMS House of Delegates, three policy statement resolutions entitled, "Relationship with Third Party Payors," "Governmental Health Insurance Program," and "ISMS Public Aid."
- Authorized the Third Party Payment Processes Committee to send IDPA a letter questioning denial of reimbursement when a hospital runs out of contracted inpatient days and an emergency patient cannot be treated.
- Authorized the Chairman to act in an expeditious manner in regard to HR 3128 which would mandate Medicare assignment for physicians performing laboratory services in their offices.
- Accepted for submission to the 1986 ISMS House of Delegates, two policy statement resolutions entitled, "Freedom of Choice," and "Governmentally Supported Health Facilities."
- Approved an Unfinished Business Report for the 1986 Annual Meeting, pertaining to Capitated Health System Insolvency Insurance. (Res. 7 A-85)
- Referred to the Governmental Affairs Council for its review a recommendation that there be support for development of legislation to permit the State of Illinois to continue to provide sufficient funding for primary care graduate medical education.
- Approved an Unfinished Business Report for the 1986 Annual Meeting, pertaining to Medicare and its effect on resident programs. (Res. 31 A-85)
- Agreed, pending review of specific legislation by the Governmental Affairs Council, that ISMS support: (1) Legislation proposed by the Department of Public Health to include Obstetrics/Gynecology as a primary care specialty under the Family Practice Residency Act; and (2) The extension of the maximum service commitment from three to four years for recipients of the Family Practice Residency Act scholarship program, should legislation of this type be proposed by the Department of Public Health.
- Agreed to offer ISMS' resources and consultation to Illinois medical schools so that they might enhance their undergraduate medical/legal curriculum.
- Accepted for submission to the 1986 ISMS House of Delegates, a policy statement resolution entitled, "Nurses—Shortage," as editorially amended.
- Referred to the Executive Committee for review an amended policy statement entitled, "Physician Recruitment Service."
- Approved an Unfinished Business Report for the 1986 Annual Meeting, pertaining to specified frequency of physician visits to nursing home patients. (Res. 29 A-85)
- Agreed to endorse the IDPH Cancer Registry and request that the state develop summary reports of the data for publication in the *Illinois Medical Journal.*
- (1) Agreed to support the new IDPH rules on tuberculosis; (2) Directed the Executive Committee to appoint a committee to develop an article on TB testing; and (3) Agreed to publish the article in the *Illinois Medical Journal.*
- Approved changes in the Department of Children and Family Services' infectious disease and sexual abuse brochures.
- Approved an Unfinished Business Report for the 1986 Annual Meeting, pertaining to psychiatric care in state hospitals. (Res. 24 A-85)
- Established June 20, 1986, as the day for the Telephone Membership Retention Project.
- Endorsed the concept of a public relations award program for both physicians and non-physicians who conduct effective public service and outreach efforts on health care issues, with the following stipulations: (1) Should be correlated with county medical society awards; (2) A rigid criteria be established; and (3) Awards should be given when indicated and not necessarily annually.
- Reviewed a policy statement entitled, "IDPA Drug Manual," and did not recommend any change in this policy statement.
- Approved publishing a report of research studies on mandatory CME in Illinois, so that results can be disseminated through such means as the *Illinois Medical Journal.*

Nominations and Appointments

Various nominations and appointments were approved or ratified by the Board, as follows:

- Approved the following list of physicians for submission to Blue Cross/Blue Shield as consultants in medical necessity determinations: Drs. Gilbert E. Blaum, Eli L. Borkon, Taylor Cope, Carey B. Dachman, Dan H. Evans, Donald P. Feeney, Saeed A. Khan, Thomas E. McNamara, James R. Pawlikowski, Benjamin J. Reichstein, Forrest H. Riordan, Eugene J. Rogers, David M. Roxe and Irving C. Sherman.
- Ratified the following physician nominees for the 1986 Team Physician Award: Drs. Hugo Avalos, Morris; William J. Gilligan, Oakbrook; David M. Hora, Arlington Heights; Albert S. Maurer, Hopedale; and J. Ellryn Rocke, Palos Hills.
- Appointed the following physicians to serve on an Ad Hoc Committee on AIDS: Drs. Ira Chasnoff, 3rd District; L. Warick Coppleson, 3rd District; Donald Graham, 5th District; LeRoy P. Levitt, 3rd District; Ronald McLawhorn, 3rd District; Richard Sassetti, 3rd District; Richard Suhs, 5th District; Gary Trager, 2nd District; and Rockford G. Yapp, III.
- Nominated the following physicians to serve on an

IDPH Advisory Committee on Alzheimer's Disease: Drs. E. Chester Bone, 6th District; Vincent Costanzo, 3rd District; Sanford Finkel, 3rd District; and Kenneth Vatz, 3rd District.

- Authorized the chairman to submit a nominee for the newly created IDPH Board of Public Health Advisers. One member of the Board is to be a physician.
- Ratified the following appointments and nominations:

  Drs. Thomas Flynn, 9th District; James Leonard, 8th District; and James West, 11th District; to serve on the Impaired Physician Panel.

  Dr. John Henderson, 4th District, to serve on the Medical-Legal Council.

  Dr. Lawrence L. Hirsch, 3rd District, nominated to serve on the AMA Ad Hoc Committee on PRO.

  Dr. David L. Spencer, 5th District, nominated to serve on the IDPH Long Term Care Facility Advisory Board.

  Dr. Lee Gladstone, 3rd District, nominated for reappointment to the IDPH Alcoholism Treatment Licensure Advisory Council.

  Dr. L. David Zinn, 3rd District, nominated to serve on the Residential Services Authority.

Programs

The Board:

- Reconsidered the site of the 1986 All-Member Conference and agreed to hold the conference on November 8-9, at the Drake Oak Brook Hotel in DuPage County.
- Approved the implementation of a program for Hospital Impaired Physician Committees, to be held on March 7, 1986.

Other Matters

The Board reviewed the following reports:

Medical Studies Act

The Society had authorized an *amicus* in a case challenging the constitutionality of the Medical Studies Act. Legal counsel reported that in two cases which have been recently reported, the constitutionality of the confidentiality of the peer review process has been upheld.

PLI Update

The Illinois Supreme Court has agreed to hear an appeal of the decision by Cook County Circuit Court Judge Wosik which declared five portions of the professional liability legislation unconstitutional. The Court further agreed that this is a critical issue and it would be heard on an expedited basis. It is anticipated that briefs will have been filed prior to January 31 on behalf of the defendants and any *amicus* briefs also would then be filed. ISMS, of course, will file an *amicus* brief, as will the American Medical Association and the Illinois Hospital Association. Plaintiff response briefs will be due February 28 with rebuttal briefs on March 15. Oral arguments will be heard late March or early April.

A campaign is being developed to educate the public, setting specific goals and strategies in order to have the public more aware of the need for reform. Additionally, there will be educational efforts to assure that persons serving on juries can more realistically reflect on costs and the impact escalating awards is having on the public.

Community Standard Rule

ISMS has submitted an *amicus* brief regarding the locality rule in a case pending at the Illinois Supreme Court. A brief and a response were received from the plaintiff shortly thereafter. The Court has had the matter under consideration since October 21, 1985, but had not rendered a decision as of January 6th.

PRO

The Crecent Counties Foundation for Medical Care is the Peer Review Organization (PRO) for Illinois. The PRO contracted with HCFA to carry out the federal mandates in utilization review for the Medicare program. Under a mandate to establish a prior approval program, some procedures which are considered to be outpatient procedures must meet certain prior approval criteria if they are to be reimbursed on an inpatient basis. The requirement does not apply in the case of emergency admissions.

These services will be approved for reimbursement on an inpatient basis provided the physician can document the medical necessity for inpatient care. CCFMC staff reviewers may approve but may not deny these admission requests.

In response to concerns about the qualifications of CCFMC reviewers, the Foundation representatives indicated that it has increased the number of physician consultants to conduct reviews for medical necessity. The Society will continue to monitor the activities of the Illinois PRO.

Informational Reports

Informational reports were presented by the Committee on CME Accreditation, Loss Prevention Education Committee, ISMIS, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section, Auxiliary, IMPAC, Speaker of the House, the AMA Delegation Chairman, and the Executive Administrator.

Next Meeting

The next Board of Trustees meeting was set for April 3-6, 1986, at the Westin O'Hare Hotel.

Adjournment

The meeting was adjourned at 2:40 p.m. ◀

Aortic Stenosis Associated with Angiodysplasia

This commentary was engendered in the course of manuscript review for Dr. Agarwal's article, "Aortic Stenosis and Gastrointestinal Bleeding of Unknown Cause," which appears on page 177 of this issue. The author, a board certified internist and gastroenterologist, provided this text in the belief that clinical controversy is an essential element of medical progress. Our editors agreed.

Despite sophisticated maneuvers currently available, gastrointestinal bleeding often eludes diagnosis. Barium studies, endoscopic studies, nuclear scintiscanning, selective angiography and exploratory laparotomy are among the diagnostic options. Still, about 5%-20% of investigations for GI bleeding fail to yield a diagnosis.

The recognition of angiodysplasia (A-V malformation, colonic vascular ectasia, telangiectasia) as a source of GI bleeding has helped explain some of this idiopathic bleeding. The pathology, incidence, and pathogenetic theories are well described by Dr. Agarwal in his article, "Aortic Stenosis and Gastrointestinal Bleeding of Unknown Cause," in this issue.

One useful clinical classification of angiodysplasia[1] might be: patients under age 50 with vascular lesions more commonly located in the stomach and small bowel and without associated cardiac disease; Osler-Weber-Rendu Syndrome; and patients over age 50 with lesions predominantly in the right colon or cecum.[2] The latter group is statistically associated with aortic stenosis.[3] Whether these categories are legitimately separated is unclear, but they do have different properties.

Diagnosis of angiodysplasia has increased with awareness of its existence and with more refined diagnostic methods. This appears to be a common entity in the elderly. Nuclear RBC labelling studies can be extremely useful if positive in directing the radiologist, surgeon, or gastroenterologist to a specific anatomic location. Angiography has been reported to have a high yield in some centers,[2] however, demonstration of angiodyslastic lesions without dye extravasation does not prove conclusively that they are the source of bleeding. Colonoscopy can dependably demonstrate vascular lesions in the right colon, less often in the small bowel; evidence of blood loss from these lesions during the exam further enhances its diagnostic accuracy.

Therapy of these lesions depends upon clinical presentation. Slow GI bleeding can be managed with oral iron repletion alone. However, for those requiring more vigorous management, endoscopic electrocoagulation or[4] laser coagulation might be useful. These procedures are considered lower risk than surgical resection, but their efficacy is also less certain. If the lesions are clearly well localized, and nonoperative modalities fail, then resection of the involved segment (usually right colon) should be curative. Scattered case reports of bleeding cessation following aortic valve replacement for aortic stenosis have been noted.

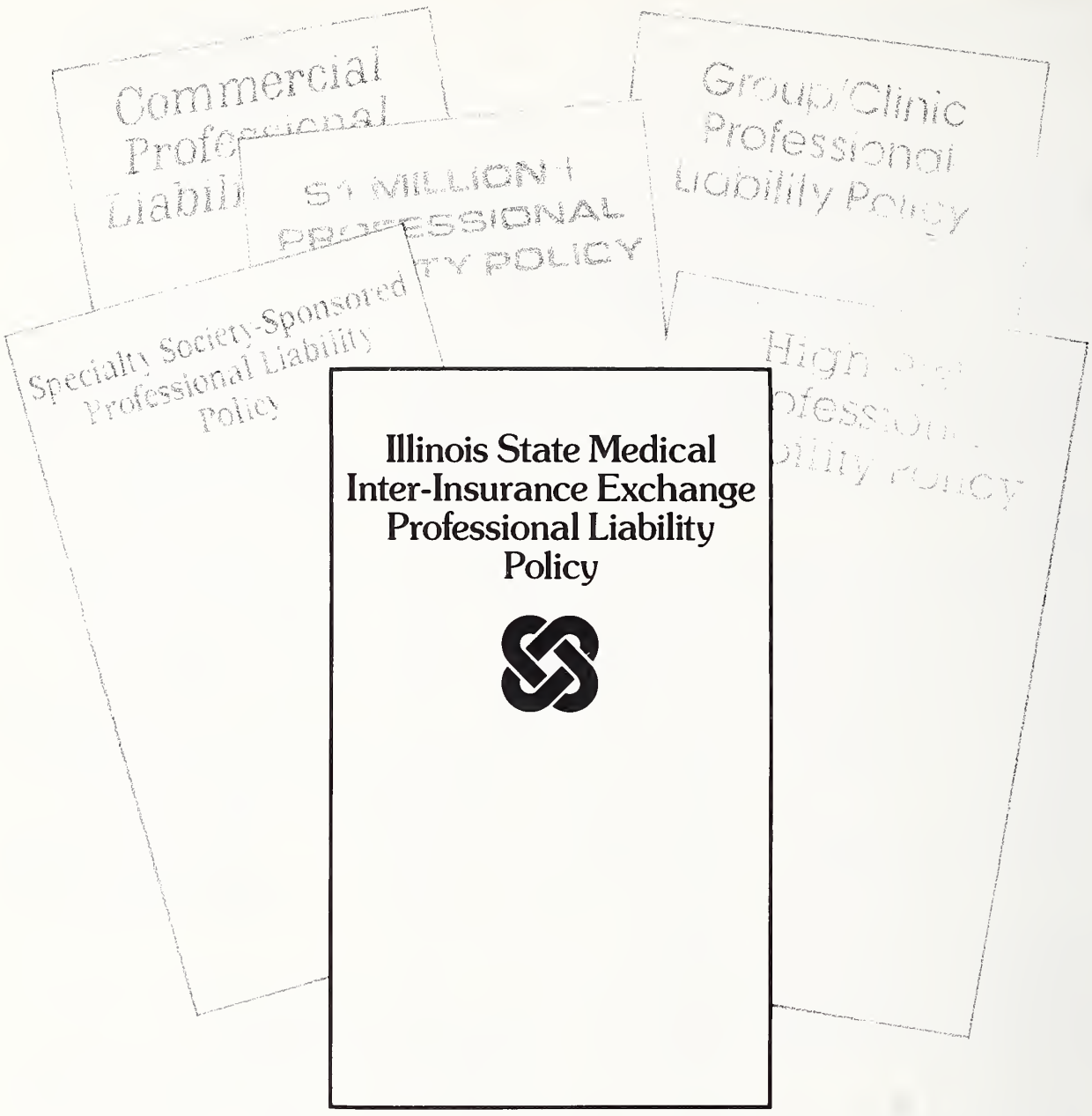
Agarwal reports a case of recurrent bleeding following such valve surgery. One wonders, in light of the usual need for anticoagulation following valve surgery, if it is wise to use GI bleeding as an indication for aortic valve surgery. The treatment of these lesions is individualized: aortic valve surgery is based on cardiovascular factors while management of angiodysplasia is based on control of bleeding.

The etiology of the association of aortic stenosis, idiopathic intestinal bleeding, and angiodysplasia is controversial.[5] It may well represent the coincidental occurrence of two relatively common clinical conditions (angiodysplasia and aortic stenosis) in an elderly population. The relationship is interesting, but does not *per se* affect management of their patients.

Michael F. Shekleton, M.D.
Clinical Assistant Professor
of Medicine
University of Illinois College of
Medicine, Peoria

References

1. Meyer, C., *et. al.*, "A-V Malformations of the Bowel: An Analysis of 22 Cases and a Review of the Literature," *Medicine* 60:36, 1983.
2. Boley, S.J., *et al,*: "On the Nature and Etiology of Vascular Ectosras of the Colon," *Gastroenterology,* 72:650, 1977.
3. Shbeeb, I., *et al,*: "The Aortic Valve-Colonic Axis," *Diseases of the Colon and Rectum* 27:38, 1984.
4. Rogers, B.H.G.: "Endoscopic Diagnosis and Therapy of Mucosal Vascular Abnormalities of the Gastrointestinal Tract Occurring in Elderly Patients and Associated with Cardiac, Vascular, and Pulmonary Disease," *Gastrointestinal Endoscopy* 26:134, 1980.
5. Cody, M.C., *et al,*: "Idiopathic Gastrointestinal Bleeding and Aortic Stenosis," *Digestive Disease* 19:393, 1974.



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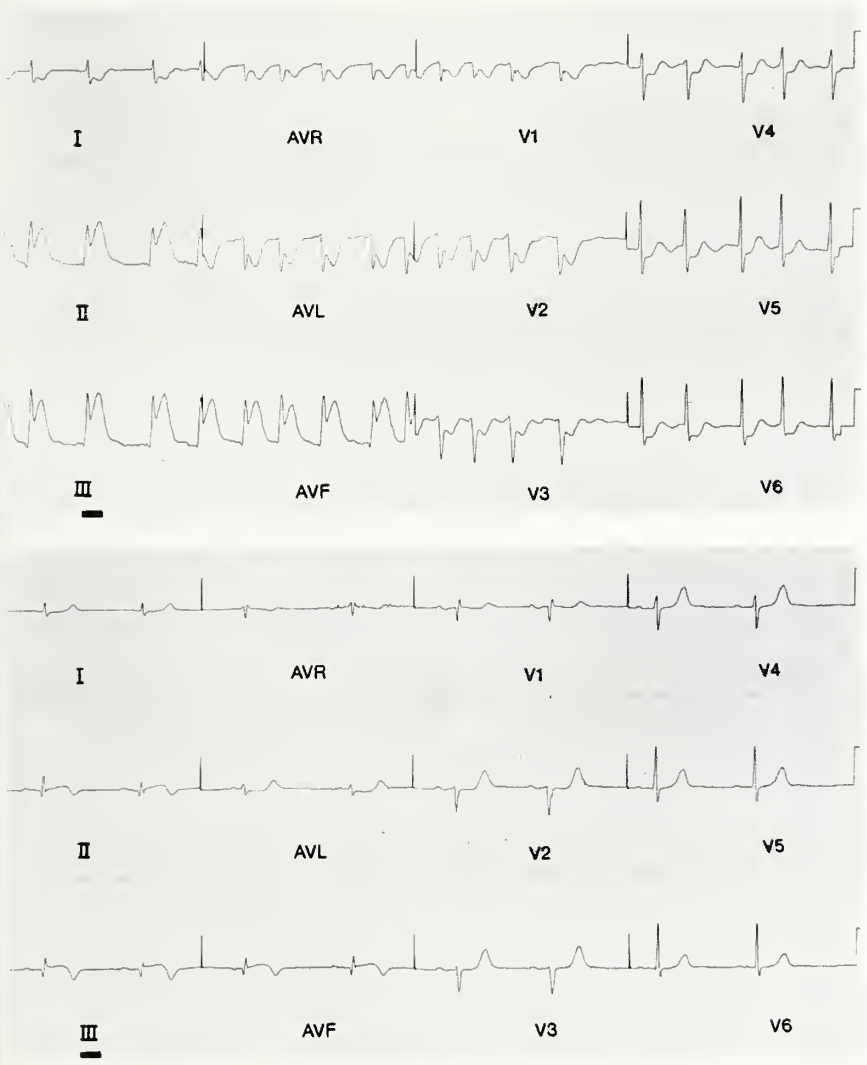
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a 69-year-old man who complained of exertional chest pain for one week that progressed to chest pain at rest. The pains were located substernally, with a tightness that radiated to both arms. He became dyspneic with the pains that occurred at rest. All pains were relieved by one sublingual nitroglycerin tablet. He was known to have peripheral arterial insufficiency and had also had aortacoronary bypass surgery in 1976. His past medical history revealed a 15 year history of hypertension and hyperlipidemia. His physical examination showed a blood pressure of 170/78mmHg, an irregular pulse, fine crepitant rales at both lung bases, and absent left femoral and bilateral dorsalis pedis and posterior tibial pulses. He was admitted to the hospital. The next morning he developed a severe substernal chest pain that was unrelieved by sublingual nitroglycerin, nifedipine, or intravenous morphine sulfate. He became hypotensive later. The first twelve lead ECG was taken at that time. The second ECG was taken after a direct current cardioversion.

Questions:

1. The two 12 lead ECGs show:
   A. Atrial fibrillation
   B. Ventricular tachycardia.
   C. A current of injury.
   D. Sinus bradycardia with evolution of the ST segment compatible with a myocardial infarction.
   E. All of the above.

2. Therapeutic options for this patient could include:
   A. Hospitalization in the coronary care unit.
   B. Medications such as nitrates and nifedipine.
   C. Streptokinase infusion.
   D. Intravenous beta blocker medication.
   E. Emergency coronary angiography.

(Continued on page 181)

Acting to Solidify Our Credibility

By George T. Wilkins, Jr., M.D., Chairman/IMPAC

The punishment of wise men who refuse to take part in government is to live under the government of unwise men.

Plato

Every election generates countless reports of apathy among the American public. We don't vote. We're not interested in how our government is operated. We're interested only when government takes an action we don't agree with—and then it's not our fault. We didn't elect that person—somebody else did. And we are not satisfied with their choice.

There's only one way to make representative government represent our choices. And that is to become involved in the political process and exercise those precious constitutional rights. Our satisfaction is likely to be directly proportional to our involvement in the choice of our representatives and in their choices once elected.

The medical community brought about dramatic changes in malpractice law in 1985. Our success can be attributed to involvement in the political process. Medicine recognized a problem and set about to correct it.

We were successful then and we will continue to be successful in the future—but only if we stay involved.

In many minds, the concept of physician political involvement came of age last year. The Illinois medical community achieved a new level of credibility in Springfield. In order to solidify that presence, we must stay on top of the political process.

The 1986 campaign season is already in full swing. The primary election is now complete and we must focus our attention on the general election November fourth. The 1986 elections offer physicians and auxilians the opportunity to continue their political education by volunteering to work in a legislative campaign.

Many friends of medicine will be standing for election this November. Some face serious opposition. Those concerned with the malpractice law situation must recognize the valuable progress brought about by our friends in the legislature. In addition, medicine can play a role in areas where an anti-medicine incumbent might be vulnerable to challenge. And, as in every election, there are open seat races. Here, medical involvement could help to elect a freshman legislator with established medical contacts.

The 1986 elections will provide us with an opportunity to demonstrate that our commitment to medical involvement in politics is a total commitment—with both financial and personal volunteer assistance. The Auxiliary has already made such a commitment. Their legislative program for 1986 under the direction of Mrs. Pat Spadoni and Mrs. Pam Taylor will place auxilians in volunteer roles in selected campaigns.

In the next several months each of us will receive many invitations to political fundraisers. We're all busy, and buying a ticket when we cannot attend personally is certainly better than failing to provide any support. Financial support is important. But this year, I'd like to urge you to find the time to attend that fundraiser. It's a terrific way to demonstrate your support and to establish and solidify the all important Key Contact relationship. Introduce yourself as a member of the medical family and offer your help in the coming election.

The legislature has made great progress in bringing equity to medical malpractice law. But our job is not done until the balance of that legislative package is passed. We must return to the legislature to seek a cap on non-economic losses and a reduced statute of limitations in these cases.

That's why the 1986 elections are so important. The lawmakers we elect in 1986 will be the decision makers when we return to the General Assembly to complete our malpractice package.

While we await the decision of the Supreme Court, we must continue our efforts to alleviate the liability crisis that worsens daily. Our success in this endeavor will depend on your involvement in the 1986 elections and your determination to finish the job in 1987. ◀

Hopefully the Kind You Sit On

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

Yesterday a "ya-but" exchange took place at the 10:00 round table, that had my neck turning like a referee in one of them tennis games!!

There was Doc Frank and our rural mail carrier—at opposite sides of the round table, if that's possible—but surely on opposite sides of the question. We observors watched the conversational ball bounce back and forth over the sugar and the moo-cow cream pitcher.

It started when Morris remarked that the doctors ought to be able to get anything at all from Washington because of their powerful lobby. "Ya, but, the postal workers have a more powerful voice to congress than anyone else!" came back Doc. "Ya but we have to do that," said Morris, "to protect our very important mail delivering function."

". . . . and our function isn't important?" fumed Doc.

Having had enough of this punishment to his aching arthritic neck, Chic called for a halt, saying, "what difference does it make? A union is a union no matter what you call it!"

"Learned professions don't have unions, they have associations or societies." spoke Asa.

"Society — Union — Association, all the same," claimed Chic. The major difference, pointed out Asa, is that a profession, while watching out for its members' interests, must always have the good of the public as its principle goal.

"True of a union too," said Morris, "if we are paid better and have better working conditions, then the public is better served."

"Not quite the same," said Asa, "and a profession has an educational responsibility—to the public, and to its members. These educational functions, more than anything else, are the difference between a union and a professional society."

The conversation swirled around Asa's point for a bit with more lining up behind Asa. "That's why you are always telling me what's good for me, Doc. . . . That's why you spend so much time reading those medical magazines, so you will know how to take care of me in my infirmity. . . . That's why you contribute to that scholarship fund, to get new young docs educated to take care of our kids."

Really an episode in intuitive learning—read that in one of your writings—all of us already knew this, but our discussion really spelled out the difference for us. Even Morris agreed that whatever activity the union engaged in, it was directly for the union members, protecting and improving the lot of the member but not with the welfare and good of the public as the first priority.

As I thought of this conversational episode later, it occurred to me that the ideal medical association must resemble a stool—hopefully the kind you sit on—and the three legged variety. To be solid and well balanced, the three legs must be equally strong and well placed. Self interest and protection through legislative and other such activities would be one leg. Public service through legislation and good advice—the recent AMA tobacco proposal—should be the second leg. Finally improvement and replication of the profession through education must be the third leg.

Anyone who has ever done any milking on a three legged stool understands how functional that stool is when all three legs are doing their part. Ya but when one of those legs is weak, or fails, . . you are likely to fall right in the straw and all.

No question but what you folks in SMSI have got a good legislative leg, and probably an ample seat. I see some learned-appearing stuff in your Journal, and a few pamphlets in Doc's office, but I have to wonder if all of the legs on your stool are equal in length and strength. Hope so!! Would surely hate to see you tip over and fall in the 'stuff.' ◀

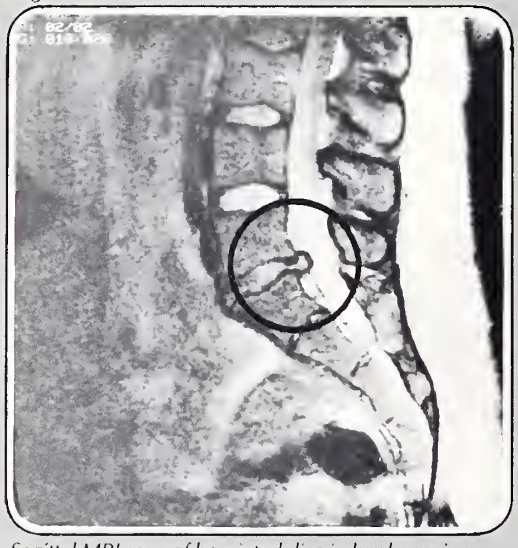


Respectfully yrs.,
E. Goodwins

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Acute Appendicitis in the Elderly

By William B. Frymark, Jr., M.D. and Olga Jonasson, M.D./Chicago

During an 11 year period, from 1970 through 1982, acute appendicitis was treated in 77 patients 60 years of age or older, representing 0.4% of the total cases during this time. Most of these elderly patients had typical symptoms: abdominal pain, vomiting, anorexia, and right lower quadrant tenderness. However, the majority presented with symptoms for longer than 36 hours. This delay was often attributable to diminished mental or physical capacity and resulted in a high (73%) perforation rate and a high (15%) mortality rate. Despite associated medical problems, the majority of deaths were septic in origin. This emphasizes the need for prompt diagnosis and aggressive operative management.

This paper was first presented before a meeting of the Chicago Surgical Society on February 4, 1983.

Acute appendicitis is a common surgical problem. It is usually characterized as a disease of young people. When appendicitis occurs in elderly patients, the diagnosis is often delayed, resulting in a well-documented increase in morbidity and mortality.[1-6] As the number of elderly persons in our society increases, the clinical problem in this group gains more importance. Despite advances in preoperative and postoperative care, mortality from acute appendicitis in people over 60 years of age remains high. We have reviewed our recent experience and identified a number of factors which appear to contribute to complications so often encountered in the elderly patient with appendicitis.

From pathology records, 77 patients aged 60 to 92 years who had undergone appendectomy for acute appendicitis during the period from January 1970 through April 1982 were identified. Cases of interval appendectomy and periappendicitis with no discernable involvement of the appendiceal mucosa were excluded. The number of appendectomies for acute appendicitis in all age groups during that same time period was approximately 2,000; this elderly group comprised 0.4% of that total. Seventy-three charts (95%) were available for review. Thirty-three patients were male and 40 were female.

Table 1

Symptoms	n	%
Abdominal pain	67	(92%)
RLQ pain	38	(52%)
mid-abdominal pain → RLQ	15	(20%)
no pain	6	(8%)
Vomiting	44	(60%)
Anorexia	30	(41%)
Constipation	11	(15%)
Diarrhea	9	(12%)

Results

Only 20% of these elderly patients gave a typical history of mid-abdominal pain migrating to the right lower quadrant, although nearly all complained of abdominal pain on admission (67 patients, 92%, Table 1). Fewer than half of the patients had symptoms for less than 36 hours. The majority (52%) had a longer duration of symptoms or were unable to give a precise history (Table 2).

Physical examination demon-

Table 2

Duration of Symptoms	n	%
<36 hours	30	(41%)
36-72 hours	13	(18%)
72 hrs.-1 wk.	21	(29%)
>1 week	4	(5%)
unknown	5	(7%)

Table 3

Physical Findings	n	%
Abdominal tenderness	72	(99%)
generalized	28	(38%)
limited to RLQ	26	(36%)
diffuse lower abdominal	10	(14%)
rectal	21	(29%)
Rebound tenderness	43	(59%)
Distention	31	(42%)
Abdominal mass	12	(16%)

strated abdominal tenderness in all but one of the patients. Over half (59%) had evidence of peritonitis, and approximately one-third had generalized abdominal tenderness on admission. Distention was found in 42% and a palpable mass in 16% (Table 3). Only five patients (7%) were afebrile on admission with most (61%) exhibiting temperatures in the range of 37.2° to 37.7°C. (99°-100°F). Three patients (4%) were hypothermic on initial examination. Leukocytosis was present in 72% of the total group. Of the 20 patients with WBC counts of less than 10,000, 14 demonstrated a left shift. Only two patients showed no leukocytosis, and both survived.

Table 4

Associated Medical Problems	n
Cardiac	37
abnormal EKG	25
history of M.I.	9
pacemaker	2
CHF	1
CNS	15
organic brain syndrome	9
CVA	6
Renal insufficiency	12
Endocrine	9
diabetes	8
s/p adrenalectomy	1
Hernias	5
Carcinoma	2
cervix	1
prostate	1
Cirrhosis	1

As would be expected in any group of older individuals, associated medical problems were seen in a large portion of patients in this series. The most common were preexisting cardiac problems (37 patients), organic brain syndrome or stroke (15 patients), renal insufficiency (12 patients), diabetes (8 patients) and hernias (5 patients). Two patients were known by history to have cancer. Another two patients' carcinoma of the cecum was discovered concurrently with acute appendicitis (Table 4).

Appendicitis was diagnosed preoperatively or was considered in the differential diagnosis in 78% of these patients. Diverticulitis was also frequently included. The other most frequent diagnosis was small bowel obstruction (six patients). All patients were treated surgically. McBurney and low midline incisions were used most commonly; a right paramedian was used occasionally. Abscesses were drained with cigarette drains and the skin and subcutaneous tissues were left open in the presence of perforation. Systemic antibiotics were given to all patients with perforation. Simple acute appendicitis was found in only 16 patients (22%); ruptured appendicitis was present in 78% of the entire group. Thirteen patients (18%) had generalized peritonitis and 35 (43%) had localized peritonitis or an abscess. The severity of the disease was directly related to the duration of symptoms (Table 5).

Sixty-one complications occurred in 41 patients (Table 6). Most of these complications were major. They included 22 infections, 10 cardiopulmonary complications, seven patients with diminished renal function and six major GI tract complications. Systemic sepsis occurred in eight patients and was fatal in all (Table 7).

Discussion

Appendicitis in the aged is a well-known clinical entity.[11] Many clinicians have stated that the clinical presentation is different from that in younger patients,[3,8] claiming that the classic symptoms and signs of acute appendicitis are often absent or quite different than expected. Our findings do not support this concept, as most patients in this study did have typical symptoms of abdominal pain, vomiting and anorexia, and had right lower quadrant tenderness. However, 12 of our patients were unable to give a precise history because of diminished mental capacity. This made diagnosis more difficult and contributed to the delay in recognition and treatment of the disease.

The course of acute appendicitis appears to be more rapid in elderly patients than in younger age groups. Thorbjarnarson[10] has cited specific anatomic changes in the appendix in older patients which may predispose to early rupture, including a thin mucosa with a paucity of lymphoid elements, fibrosis and fatty infiltration of the muscular wall. Additionally, sclerosis of both arteries and veins predisposes

Table 5
Duration of Symptoms and Operative Findings

Duration of Symptoms	n	(%)	Simple	Gangrenous	Localized Peritonitis	Localized Abscess	Generalized Peritonitis	Death
<36 hours	30	(41%)	14	5	1	7	3	1
36-72 hours	13	(18%)	1	4	1	4	3	0
72 hrs-1 wk	21	(29%)	1	1	5	10	4	6
>1 week	4	(5%)	0	0	0	4	1	3
unknown	5	(7%)	0	0	0	3	2	1

Table 6
61 Postoperative Complications Occurring in 41 Patients

Minor (16)	Major (45)	
atelectasis	infection	22
arrhythmia	cardiopulmonary	10
urinary tract infection	renal	7
ileus	GI tract	6
minor wound infection		

to ischemia when intraluminal pressure increases. The majority of patients in our study (78%) had ruptured appendicitis, including half of the patients with symptoms of 36 hours or less in duration. In contrast, the perforation rate in one large series of pediatric appendicitis at our facility[9] was only 35%,

Table 7

Major Postoperative Infections	n	Deaths
Systemic sepsis	8	8
Pneumonia	6	
Wound infections and dehiscence	7	
DIC	1	–
	22	8

although the mean duration of symptoms before surgery was 48 hours.

As expected, both the number of associated medical problems and the complication rate were high.[3,4,7] Despite these associated medical problems, 8 of the 11 deaths were directly attributable to uncontrolled sepsis. The other deaths were due to cardiopulmonary causes. These findings emphasize the urgent need for surgical control of the septic focus.

Conclusion

Ludbrook and Spears[12] have determined that the risk of developing acute appendicitis at the age of 50 is 1 in 35 for males and 1 in 50 for females. By the age of 60, the rates are approximately 1 in 50 for males and 1 in 70 for females. Although these risks are not large in themselves, the average life expectancy in this country is now well over 70 years of age and the population over age 60 is continuing to rise. Delay in presentation of the patient to the hospital is unavoidable in most instances. When an elderly patient does present to the surgeon with lower abdominal pain, right lower quadrant peritonitis and distention, the index of suspicion of acute appendicitis should be high, and an aggressive surgical approach with early surgical exploration should be adopted. Perhaps incidental appendectomy should be more liberally applied, even in older patients undergoing elective surgery for other conditions. ◀

References

1. Peltokallio, P., Jauhianen, K.: "Acute Appendicitis in the Aged Patient," *Arch Surg* 100:140-143, 1970.
2. Peltokallio, P., Tykka, H.: "Evolution of the Age Distribution and Mortality of Acute Appendicitis," *Arch Surg* 116:153-156, 1981.
3. Williams, J.S., Hale, H.W. Jr.: "Acute Appendicitis in the Elderly: Review of 83 Cases," *Ann Surg* 162:208-212, 1965.
4. Hubbell, D.S., Barton, W.K., Solomon, O.D.: "Appendicitis in Older People," *Surg Gynecol Obstet* 110:289-292, 1960.
5. Mittlepunkt, A., Nora, P.F.: "Current Features in the Treatment of Acute Appendicitis: An Analysis of 1,000 Consecutive Cases," *Surgery* 60:971-975, 1966.
6. Reeves, M.M., Meredith, D., Lewis, F.J.: "Appendicitis in the Older Patient," *Surg Gynecol Obstet* 106:610-612, 1958.
7. Owens, B.J. III, Hamit, H.F.: "Appendicitis in the Elderly," *Ann Surg* 187:392-396, 1978.
8. Albano, W.A., Zielinski, C.M., Organ, C.H.: "Is Appendicitis in the Aged Really Different?" *Geriatrics* 30:81-88, 1975.
9. Janik, J.S., Firor, H.V.: "Pediatric Appendicitis," *Arch Surg* 114:717-719, 1979.
10. Thorbjarnarson, B., Loehr, W.J.: "Appendicitis in Patients Over the Age of 60," *Surg Gynecol Obstet* 110:289-292, 1967.
11. Wood, C.B.: "Acute Appendicitis in the Aged: A Study of 43 Cases Occurring After the Age of 60," *Amer J Surg* 26:321-325, 1934.
12. Ludbrook, J., Spears, G.F.S.: "The Risk of Developing Appendicitis," *Br J Surg* 52:856, 1965.

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Olga Jonasson, M.D., is a board certified surgeon and chief of surgery at Cook County Hospital in Chicago. A professor of surgery at the University of Illinois College of Medicine, Dr. Jonasson has served as the president of the Illinois Transplant Society as well as the University of Illinois medical staff president. Her credentials include service on numerous editorial boards and commissions, awards in education, and community service activities.

Arising from the Pulmonary Artery

Anomalous Left Coronary Artery

By Robin L. Noe, M.D. Edward F. McKenney, D.O. and H. Weston Moses, M.D./Springfield and Carthage

The case of an asymptomatic 49-year-old woman with a coronary arteriovenous fistula is reported. The left coronary artery arises from the pulmonary artery. Survival to adulthood is attributed to the extensive collateral circulation between the normally arising right coronary artery and the left coronary artery. This collateral flow has also resulted in a shunt with flow from the right coronary artery to the pulmonary artery.

Anomalous origin of the left coronary artery from the pulmonary artery is rare. Still, it remains the most common of the isolated congenital coronary artery anomalies. The overall estimated incidence is approximately one in 300,000 live births.[1] Characteristically, an infant healthy at birth begins to have signs and symptoms of congestive heart failure at two to three months of age.[2,3] Most untreated patients with this defect die in the first year of life. Coronary arteriovenous fistula may be associated with this condition, in that blood flows from the right to the left coronary artery and into the pulmonary artery. We report the case of an asymptomatic 49-year-old woman found to have an anomalous left coronary artery originating from the pulmonary artery with a coronary arteriovenous fistula.

Case Report

A 49-year-old woman was noted on routine physical examination to have a continuous systolic and diastolic murmur at the left sternal border. The patient related a history of cardiac murmur since infancy, but had since been asymptomatic. On physical examination, the patient had brisk carotid upstrokes and a wide pulse pressure. Heart rate was regular and a II/VI systolic ejection murmur was heard. The murmur radiated poorly to the carotids and III/VI diastolic murmur, which had an unusual high pitched quality, was localized at the left sternal border. Femoral and pedal pulses were normal. An ECG demonstrated left ventricular hypertrophy with strain pattern and an echocardiogram was normal. She was admitted to the hospital and underwent cardiac catheterization. Left ventricular contractility was borderline low, although the left ventricle was not enlarged. Aortic root injection did not show aortic regurgitation but showed a massively dilated right coronary artery with a diameter of approximately one centimeter. Selective visualization of the right coronary artery was difficult because of the massive dilatation with brisk flow through it. A 7 French catheter had to be exchanged for an 8 French catheter and a power injector was used in order to adequately visualize the coronary artery. The right coronary circulation supplied the entire heart and provided extensive collateral circulation to the left coronary artery. The left coronary artery orifice was totally absent from the aorta and the artery originated from the pulmonary artery. Dye flowed from the right to the left coronary artery and into the pulmonary artery. (Figure 1) Oxygen saturations indicated an approximate 2.5 to 1 left-to-right shunt. The pulmonary artery pressures were normal with no pulmonary hypertension.

An exercise MUGA scan was performed to assess the effect of the shunt on the heart. This showed an abnormal response with a decrease in ejection fraction from 50%-38%

during stress (rather than the normal rise in ejection fraction with exercise). The patient is currently contemplating surgical correction of the fistula to the pulmonary artery.

Discussion

A left coronary artery originating from the posterior aspect of the pulmonary artery, usually near its base, is the most common anatomic type of this anomaly and was first clinically described by Bland, White and Garland.[4] The right coronary artery arises normally from the right anterior coronary sinus of the aortic sinus and, if the patient survives beyond infancy, noticeable dilatation is present.

During infancy, flow through the anomalous left coronary artery and perfusion of the anterior and anterolateral left ventricular walls decreases as the pulmonary artery pressure declines. This results in possible ischemia, myocardial infarction with heart failure, mitral incompetence secondary to papillary muscle infarction, ventricular tachyarrhythmia or death.

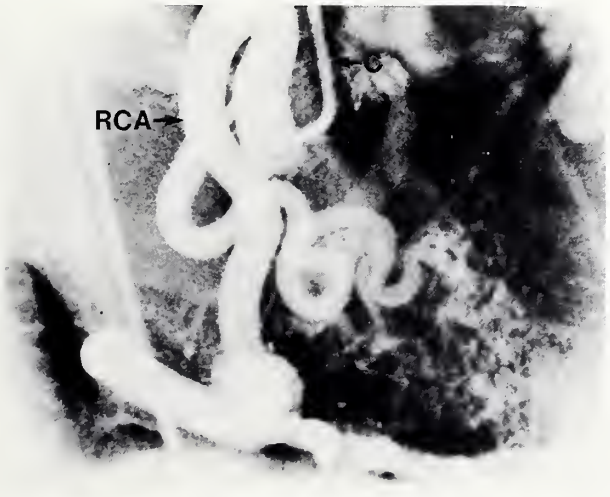
Those who survive to adulthood without early surgical intervention, as our patient did, depend upon development of collateral perfusion from the normally arising right coronary artery to the left coronary artery. With reversal of flow in the anomalous left coronary artery into the pulmonary artery, the entire myocardium can be supplied via the right coronary artery.

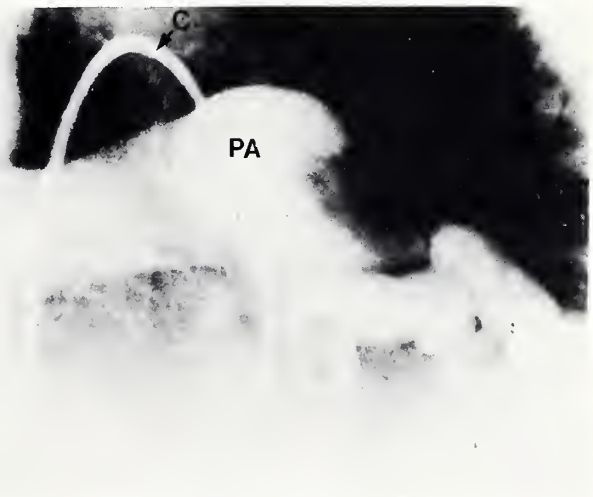
The signs and symptoms in adolescents and adults with this anomaly vary widely, from the absence of symptoms to exertional angina and ventricular tachyarrhythmia and to acute or remote myocardial infarction and sudden death.[5] Our patient was asymptomatic, but upon discovery of a continuous precordial murmur, further investigation was undertaken.

The seriousness of this defect in children reinforces the need for early surgical treatment of all infants with this lesion, whether symptomatic or not. As an asymptomatic middle-aged adult, our patient presents a more difficult clinical decision. She does, however, have a significant left-to-right shunt, evidence of left ventricular hypertrophy on ECG and an abnormal response to exercise. Elective surgical correction has been offered her. The best course is somewhat uncertain, since only a small number of adults with this condition have ever been described with long-term follow-up information. Surgery has been recommended in older children and adults because of frequent reports of sudden death among untreated patients.[2,6,7] The surgical alternatives for an adult include ligation of the left coronary artery at its origin from the pulmonary artery, with or without aortocoronary bypass graft by means of a reversed saphenous vein graft. Aortic reimplantation of the left coronary artery has also been performed.[8] Vein grafts have been used, especially in older children and adults. This is probably the method of choice in adults for two reasons. The first is a larger surgical experience with acquired coronary artery disease among adults.[9] The second is the technical difficulty of aortic reimplantation which has been encountered in that group.[8]

Addendum

The patient agreed to surgery. Dr. Joel Schneider performed closure of the orifice of the anomalous left coronary artery and double coronary artery bypass utilizing the right internal mammary artery to the circumflex marginal and the left internal mammary artery to the anterior descending coronary artery. The patient tolerated the pro-





(RCA = right coronary artery, C = catheter, PA = pulmonary artery)

Figure 1A: Markedly dilated right coronary artery visualized with power injector. The 8 French right preformed catheter allows size comparison. Multiple collaterals to the left coronary artery are faintly seen.

Figure 1B: View of the pulmonary artery a few seconds after initial injection. Note the change in view in relation to the position of the catheter. The pulmonary artery is well visualized with preferential flow to the right main pulmonary artery.

cedure well and is doing well five months postoperatively.

References

1. Keith, J.D.: "The Anomalous Origin of the Left Coronary Artery from the Pulmonary Artery," *Br Heart J* 21:149-161, 1959.
2. Wesselhoeft, H., Fawcett, J.S., Johnson, A.L.: "Anomalous Origin of the Left Coronary Artery from the Pulmonary Trunk. Its Clinical Spectrum, Pathology and Pathophysiology Based on a Review of 140 Cases with Seven Further Cases," *Circulation* 38:403-425, 1968.
3. Gasul, B.M., Arcilla, R.A., Lev, M.: HEART DISEASE IN CHILDREN, Philadelphia: Lippincott, p. 995, 1966.
4. Bland, E.F., White, P.D., Garland, J.: "Congenital Anomalies of the Coronary Arteries: Report of an Unusual Case Associated with Cardiac Hypertrophy," *Am Heart J* 8:787-801, 1933.
5. Liberthson, R.R.: "Congenital Anomalies of the Coronary Arteries," *Cardiovasc Med* 9:857-869, 1984.
6. George, J.M., Knowlan, D.M.: "Anomalous Origin of the Left Coronary Artery from the Pulmonary Artery in an Adult," *N Engl J Med* 261:993-998, 1959.
7. Flamm, M.D., Stinson, E.B., Hultgren, H.N., *et al*: "Anomalous Origin of the Left Coronary Artery from the Pulmonary Artery," *Circulation* 38:113-123, 1968.
8. Moodie, D.S., Fyfe, D., Gill, C.C., Cook, S.A., Lytle, B.W., Taylor, P.C., Fitzgerald, R., Sheldon, W.C.: "Anomalous Origin of the Left Coronary Artery from the Pulmonary Artery (Bland-White-Garland Syndrome) In Adult Patients: Long-Term Follow-Up After Surgery," *Am Heart J* 106:381-388, 1983.
9. Stephenson, L.W., Edmunds, L.H., Friedman, S., Meijboom, E., Gewitz, M., Weinberg, P.: Subclavian-Left Coronary Artery Anastomosis (Meyer Operation) for Anomalous Origin of the Left Coronary Artery from the Pulmonary Artery," *Circulation* 64:II 130-133, 1981.

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Colon Carcinoma in Inguinal Hernia

By Krishnan Sriram, M.D. and Ronald L. Nichols, M.D./ North Chicago and New Orleans, Louisiana

Two unusual cases of colon carcinoma presenting as inguinal hernias are reported and their association is discussed. One involves the cecum and the other the sigmoid colon. Palpation of a hard mass in an inguinal hernia warrants further workup. A preoperative diagnosis of colon carcinoma enables the surgeon to plan a suitable operative approach.

The association between colon carcinoma and inguinal hernia has been debated, especially with regard to the cost effectiveness of screening patients. Sliding inguinal hernias are relatively rare, and colon carcinoma within a hernial sac is even rarer. Gross[1] reported on this association in 1980 with two new cases: the first report of an ascending colon carcinoma in an inguinal hernia, and what is said to be the twelfth case of a left colon carcinoma in an inguinal hernia. We report two similar cases, one with a cecal carcinoma, and the other with a sigmoid colon carcinoma, presenting as sliding inguinal hernias.

Case One

A 63-year-old obese white male patient presented to the hospital with a large left groin mass which had been present for four years. A left inguinal hernia repair had been performed 25 years earlier. Upon examination, a large, irreducible left inguinal hernia was noted with a hard mass in the hernial sac. Both testes and the contralateral groin were normal. Examination of other systems revealed no abnormality.

Stool test for occult blood was positive. Barium enema examination revealed that the sigmoid colon, with a filling defect, was present in the hernial sac. (Figure 1) At colonoscopy, a friable necrotic mass was noted at 60cm.

Multiple biopsies were taken. The illuminated tip of the colonoscope could be easily seen through the scrotal skin. A marble-sized pedunculated polyp was noted about 45cms proximal to the necrotic lesion. Biopsy specimens from the polyp showed acute and chronic inflammation, but malignancy could not be ruled out. Biopsies from the necrotic mass were inconclusive. Liver scan was normal. Liver-associated enzymes and carcinoembryonic antigen (CEA) levels were normal.

The patient was prepared for surgery with mechanical and antibiotic bowel preparation following the protocol described by Nichols.[2] At laparotomy, the hernia was confirmed to be of a direct type. The fascial defect was enlarged and the hernia reduced by gentle traction. The cord and testis were separated from the scrotum. Colon resection was then performed and the mid-descending colon was anostomosed to the rectum. There were no postoperative complications.

The resected specimen showed a large, ulcerated lesion, 4.5cms in diameter, from which microscopic



Figure 1

sections showed adenocarcinoma. Sections from the polyp showed atypical mucosal changes. Five out of 12 lymph nodes had metastases.

Case Two

An 85-year old male who had been passing blood in his stools for three days was admitted. Physical examination showed a left-sided colostomy with blood-tinged stools in the bag. An incarcerated right inguinal hernia was noted and a hard mass could be felt in the hernial sac.

The patient's past history is interesting. At age 56 he had undergone an abdomino-perineal resection for villous adenoma of the rectum. At age 73, an adenomatous polyp was removed with a snare through a proctoscope at 8cm from the colostomy. Examination at this time had also revealed a ventral hernia and a right inguinal hernia. It was determined that neither would be repaired.

At age 76 he was worked up for bleeding through the colostomy. The remaining part of the descending colon which contained two polyps was excised. A distal transverse colostomy was created. The polyps were benign. At age 81 he was admitted with an incarcerated right inguinal hernia. At emergency exploration, no gangrene of bowel was found and the hernia was repaired. At age 82 he was again admitted with bleeding through the colostomy. No cause could be ascertained after extensive workup. A recurrence of the right inguinal hernia was noted. The ventral hernia persisted.

As described, an incarcerated right inguinal hernia with a hard mass was detected at the present admission. Barium enema and colonoscopy showed a tumor in the cecum. This was confirmed by biopsy to be an adenocarcinoma. Standard preoperative bowel preparation was used, and at surgery the abdomen was opened by a transverse incision. The ventral hernia sac was opened and the peritoneal cavity was entered. The cecum with its tumor was found to form the sliding inguinal hernia. The cecum and ascending colon were resected and an ileo-transverse colic anastomosis was performed. The inguinal hernia, as well as the ventral hernia, were closed with #28 stainless steel wire. The postoperative course was uneventful and the patient was known to be doing well four years after this admission.

Discussion

The routine use of barium enema examination in patients with inguinal hernia has been controversial. Juler and others[3] do not support routine use of barium enema to detect occult colon carcinoma in patients with "asymptomatic" inguinal hernia. Davis and Jackson[4] believe that any patient whose hernia originated recently or recently became symptomatic, should be investigated for colon cancer, particularly patients over age 55. Palpation of a hard mass in an inguinal hernia, especially when incarcerated or associated with signs and symptoms of obstruction,[5] certainly warrants further workup. In addition to colon tumors which are easily detected by barium enemas and colonoscopy, tumors of the testes, spermatic cord[6] and bladder[7] also must be considered. Metastases from large bowel,[6] kidney[8] and other unusual locations[9] have been reported.

A preoperative diagnosis of carcinoma within an inguinal hernial sac enables the surgeon to prepare the patient for definitive cancer surgery at the time of hernia repair. This was done in both of our patients. For this reason, a laparotomy is essential to ascertain the extent of the disease prior to resection of the colon. Enlarging the fascial defect enables the surgeon to reduce the hernia without undue manipulation. ◀

References

1. Barry, H.G., Botsford, J.A., Colley, D.P.: "Colon Carcinoma In a Right Inguinal Hernia," *J Can Assoc Radiol* 31:145-146, 1980.
2. Nichols, R.L., Condon, R.E., Gorbach, S.L., Nyhus, L.M.: "Efficacy of Preoperative Antimicrobial Preparation of the Bowel," *Ann Surg* 176:227-232, 1972.
3. Juler, G.L., Stemmer, E.A., Fullerman, R.W.: "Inguinal Hernia and Colorectal Carcinoma," *Arch Surg* 104:778-780, 1972.
4. Davis, W.C., Jackson, F.C.: "Inguinal Hernia and Colon Carcinoma," *CA* 18:143-145, 1968.
5. Javors, B.R., Bryk, D.: "Colonic Obstruction Within Inguinal Hernia," *J Can Assoc Radiol* 32:162-163, 1981.
6. Roslyn, J.J., Stabile, B.E., Rangenath, C.: "Cancer in Inguinal and Femoral Hernias," *Am Surg* 46:358-362, 1980.
7. Haywood, I.R.: "Hernia: Benign or Malignant?" *Postgrad Med J* 58:542-544, 1982.
8. Kanzer, B., Rosenberg, R.F.: "Unusual Contents in Inguinal Hernia Sacs," *NY State J Med* 1055-1056, 1983.
9. Yoell, J.H.: "Surprises in Hernial Sac," *California Med* 91:146-148, 1959.

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Perirenal and Intrarenal Hematoma

Sonographic Diagnosis of Fractured Kidney

By Parachuru R. Prasadarao, M.D., Mohammad Naseem, M.D. And Ramakrishna Devasthali, M.D./Chicago

At this writing, only one sonographic diagnosis of fractured kidney has been reported.[1] Fractured kidney is a rare complication of blunt trauma to the abdomen. Whenever there is a high clinical suspicion of renal trauma and fractured kidney, sonography can provide an accurate diagnosis and guide to correct treatment. We describe a case where urography and angiography failed to give a correct diagnosis, resulting in the delay of appropriate treatment.

A previously healthy 19-year-old black female with no significant medical or surgical history was struck by a car on the right side while crossing a street. The impact threw the patient an undisclosed distance and caused several minutes' unconsciousness. The patient received emergency care at another facility and was transferred to our institution later on the day of the injury.

The initial evaluation revealed abrasions of the face and right forearm, a spontaneously reduced dislocation of the right knee with evidence of multiple ruptures in ligamentous structures and right flank tenderness. Gross hematuria was noted. Relevant initial lab data included Hct34%, BUN 12 and creatinine 0.9. An excretory urogram (Figure 1) showed a small right kidney which was thought to be hypoplastic; the left kidney was entirely normal. An abdominal aortogram and selective right renal arteriogram (Figure 2) revealed a deformed right kidney, 8.5cm. in length, which was markedly smaller than the left and was reported as right renal hypoplasia predominantly of the upper pole with moderate stenosis of the origin of the right superior interlobar artery.



Figure 1. Excretory urogram—suboptimal visualization, diminished size and delayed function of the right kidney.

Four days later, the patient underwent repair of the ruptured ligaments of the right knee and open reduction and internal fixation of an avulsion fracture of the proximal fibula. In the postoperative period, she continued to complain of right flank tenderness and a 15×15cm. mass became palpable in this area. Gross hematuria had resolved and U/A showed 3-5RBCs per HPF. BUN/creatinine continued to be normal and the hematocrit was noted to be 27%. A radionuclide liver-spleen scan was then done and showed a defect in the area of the gallbladder interpreted as a prominent gallbladder fossa.



Figure 2. Nephrogram phase of right renal artery injection reveals nonvisualization of the upper pole with apparent stenosis of the origin of the superior interlobar artery.

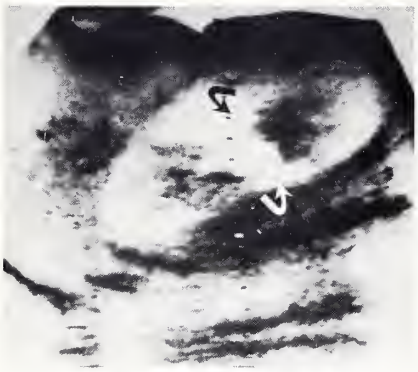


Figure 3A. Longitudinal sonogram of the right kidney in supine position depicts the anechoic area (arrows) in the interpolar region representing fractured kidney and intrarenal hematoma.



Figure 3B. Transverse sonogram of the right kidney in supine position shows a large anechoic area (arrows) representing hematoma at the level of fracture.

However, a sonogram of the liver was obtained to rule out the possibility of a subcapsular hematoma. The study (Figures 3A-B) depicted a normal liver, but the right kidney was found to be enlarged with a break in the continuity of the renal parenchyma and fluid collection within and around its interpolar region. This was thought to represent a right renal fracture with intrarenal and perirenal hematoma and was reported as such. Surgical exploration on the following day confirmed the sonographic diagnosis. A necrotic right upper pole with a large intra- and perirenal hematoma was found. The hematoma was drained and a partial nephrectomy was successfully performed.

Discussion

Blunt trauma to the kidney may be responsible for intrarenal and perirenal hematoma which can be well demonstrated by ultrasonography. An associated partial or complete fracture of the kidney may also be ruled out with this process, especially where urographic and angiographic findings are equivocal. On sonography, a linear absence of echoes[2] or a linear echogenic mass[3,4] across the renal parenchyma and calyceal region are characteristic findings of a fractured kidney.

In this case, a urogram showed poor functioning of the involved kidney. Angiographic findings were not clear and were interpreted as hypoplastic kidney. The treatment was delayed for several days until a sonographic examination was done to rule out a mass or subcapsular hematoma in the liver. The sonographic findings in the right kidney were fairly typical of a fractured kidney.

In cases of blunt trauma to the abdomen or lumbar region with high suspicion of renal injury, sonography and urography can provide useful information about the injury and renal or perirenal hematomas. We believe that sonography should be the first examination of choice in such cases. During the postoperative period, sonography provides a reliable evaluation of the renal fossae. ◀

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References

1. Afschrift, M., De Sy, W.: "Fractured Kidney and Retoperitoneal Hematoma Diagnosed by Ultrasound," *J Clin Ultrasound* 10:335-336, September 1982.
2. Kay, C., Rosenfield, A., Armm, M.: "Gray Scale Ultrasonography in the Evaluation of Blunt Renal Trauma," *Radiology* 134:461, 1980.
3. Redmond, A., Dieval, M., Grumback, Y., *et al:* "Apport de l'Echotomographie Urgence dans les Traumatismes Renaux, " *Sem Hop Paris* 56:867, 1980.
4. Schmoller, H., Kunit, G., Frick, J.: "Sonography in Blunt Renal Trauma," *Eur Urol* 7:11, 1981.

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Aortic Stenosis and Gastrointestinal Bleeding of Unknown Cause

By Ashok K. Agarwal, M.D., F.A.C.C./ Carbondale

Calcific aortic stenosis of the elderly is increasingly associated with bleeding angiodysplasia of the gastrointestinal tract. The exact pathogenesis of this association is not known. Bleeding is usually recurrent, with no known precipitating and relieving factors. Selective angiography is frequently needed to demonstrate the angiodysplasia. Aortic valve replacement probably does not affect and is not recommended as a treatment for recurrent gastrointestinal bleeding secondary to angiodysplasia of the gut.

Gastrointestinal bleeding of unknown etiology presents a difficult diagnostic and therapeutic problem. Cryptogenic gastrointestinal bleeding occurs more frequently in elderly patients with calcific aortic stenosis. This association was first mentioned by Heyde[1] in 1958 and many others have corroborated his findings. In a review of 37,243 hospital admissions, Goldman[2] found three times as many cases of combined aortic stenosis and gastrointestinal bleeding as was expected from statistical analysis. In 40% of these (6 of 15) no cause for gastrointestinal bleeding was determined. In a study of 1,443 patients with gastrointestinal bleeding, 95 (6.5%) were unexplained, and of these, 25% had aortic stenosis.[3] Cody, *et al*,[4] found the prevalence rate for idiopathic gastrointestinal bleeding in patients with aortic stenosis to be 2.6%, which was significantly higher than that of the control group. In one series of patients admitted for valvular surgery,[5] a higher incidence of gastrointestinal bleeding was found in the aortic group (12%) than in the mitral group (4%). In 20% of the aortic group a source of bleeding was not identified.

Pathogenesis

Common disorders such as peptic ulcer disease may cause bleeding. However, angiodysplasia[6] (vascular octasias, vascular malformations, vascular dysplasia, mucosal vascular abnormalities) of the gut is the usual cause of cryptogenic gastrointestinal bleeding associated with calcific aortic stenosis.[7-10] The pathogenesis of angiodysplasia is unknown, but several theories have been proposed.

Boss and Rosenbaum,[10] suggested the possibility of combined congenital vascular malformation of the gastrointestinal tract and congenital bicuspid aortic valve. Cody, *et. al.*,[4] refuted this theory on the basis that none of their patients, in whom the anatomy of the aortic valve was defined, had congenital bicuspid aortic valve. Most studies and case reports in the literature have not described the anatomy of the aortic valve. This may be because the valve is found to be so disorganized by calcification that it is difficult to count the number of cusps (idiopathic calcific aortic stenosis).

Willams[3] and Cody, *et. al.*,[4] raised the possibility that low perfusion and low pulse pressure produced by aortic stenosis might contribute to the development of angiodysplasia. Cardiac output is usually well maintained until the late stage of aortic stenosis.[11] For that reason, decreased tissue perfusion is not the explanation for the development of angiodysplasia. As most of these patients are elderly, diffuse visceral atherosclerotic narrowing with peripheral ischemia predisposing the intestine to bleed after minimal physiologic trauma[3] has also been implicated. Selective arteriograms in these patients and autopsy or surgical cases do not support this theory.

Boley, *et. al.*,[12] have found that

vascular ectasias are common degenerative lesions of aging. They believe that aortic stenosis, which is present in 20%-25% of patients with bleeding angiodysplasia, does not contribute to development of vascular ectasias, but rather increases the chance of bleeding in persons who have ectasias. It is their opinion that low perfusion pressure caused by aortic stenosis may cause ischemic necrosis of the single layer of endothelium which often separates ectatic vessels from the colonic lumen. As mentioned above, cardiac output is usually normal in aortic stenosis until the late stage of the disease; low tissue pressure is an unlikely explanation.

An Hypothesis

It is possible that the process resulting in disease of the aortic valve is in some way related to the process that causes the development of areas of angiodysplasia. Galdabini[6] has discussed cholesterol emboli to the gastrointestinal tract as a possible cause of angiodysplasia. Mitsudo, *et. al.*,[13] found cholesterol emboli in four colon specimens but did not believe them to be a cause. In the elderly, aortic stenosis appears to be caused by age-related degenerative changes from wear and tear through the years in a normal valve. Roberts[14] believes that these degenerative changes are related to atherosclerosis, because these occur only in people with blood cholesterol levels more than 200mg/100ml. It is conceivable that abnormalities of cholesterol metabolism provide a common mechanism for both degenerative changes, calcific aortic stenosis of the elderly and angiodysplasia of the gastrointestinal tract. This may help explain the increased association of the two conditions. It is possible that aortic stenosis neither contributes to the development of angiodysplasia nor increases the change of bleeding from angiodysplasia.

Clinical Presentation

Gastrointestinal bleeding associated with aortic stenosis may occur in upper or lower gastrointestinal tracts, or both. Most patients in the literature are more than 60 years of age. No sex-related predilection has been noted. Bleeding occurs spontaneously without any known precipitating factors. It is frequently recurrent with periods between bleeds varying from months to years. Bleeding usually is low grade but patients occasionally present with acute massive bleeding. The nature and degree of bleeding frequently varies in the same patient with different episodes and usually stops spontaneously. The patient may have the usual signs and symptoms of aortic stenosis or may be asymptomatic.

Investigations

Several methods are used to determine the cause of gastrointestinal bleeding.[15] These include routine x-ray examination of the gastrointestinal tract (upper GI, barium enema); endoscopy (gastroscopy, sigmoidoscopy, colonoscopy); selective arteriography; abdominal exploration; and various other tests. The x-ray examinations of the gastrointestinal tract are consistently negative, because the vascular lesions create no mass effect. Endoscopy[16,17] also is frequently unrewarding but may occasionally be helpful in detecting angiodysplasia. For many reasons, endoscopy is frequently negative in angiodysplasia.[7] (Frequently there is no mucosal component of the angiodysplasia; mucosal lesions when present are usually flat and may be hidden between gastric or colonic folds.) These lesions may be mistaken for trauma from the endoscope, nasogastric tube or suction artifact. A repeat endoscopy when bleeding has slowed or stopped may sometimes reveal vascular lesions, despite negative endoscopy during active bleeding. The vascular lesions may be circumscribed or irregular, with a fern-like pattern bleeding into the surrounding normal mucosa[7] or a cherry-red dilated array of vessels.[9]

An awareness of the condition and a high index of suspicion are helpful in making the diagnosis of angiodysplasia of the gut. It should be strongly considered in any older patient with chronic, intermittent gastrointestinal bleeding and negative x-ray and endoscopic examinations. Selective arteriography (celiac, superior mesenteric, and inferior mesenteric) is frequently needed to demonstrate the angiodysplasia.

Sprayregen and Boley[18] have described the angiographic signs of angiodysplasia. The earliest and most frequent sign is a densely opacified, dilated, tortuous, slowly emptying intramural vein representing ectatic changes in a submucosal vein. The more advanced lesion is represented as a vascular tuft corresponding to the extension of degenerative process to the venules in the mucosa. A vascular tuft is a small, candelabra-like or oval cluster of vessels best identified in the arterial phase, which empties slowly and can be observed in venous phase. A late sign is an early filling vein which reflects an arteriovenous communication through a dilated arteriolar-capillary-venular unit.

The early filling vein is one that fills during the late arterial phase of the angiogram. Extravasation of contrast material is only occasionally seen in angiodysplasia. Distension of colon with air[18,19] prior to performing arteriogram and use of magnification technique[19] can be quite useful in demonstrating the vascular abnormalities.

Pathology

Angiodysplastic lesions are generally less than 1cm. in diameter. They cannot usually be identified at surgery, or even on routine gross and microscopic examination of the operative specimen[8,9,17] (Emperor's-clothes-syndrome[6]). When sections are made through the lesions using special techniques,[8,9,13] findings are consistent with angiodysplasia. These consist of dilated, distorted, thin-walled vessels, mostly lined by endothelium and, less frequently, by a small amount of smooth muscle.[13] The degree of distortion of the normal vascular architecture varies in different lesions, but the most consistent abnormality is the presence of dilated submucosal veins.[13] Sometimes there is thickening of the walls of the veins seen denoting a high pressure flow. Areas of angiodysplasia in the upper and lower gastrointestinal tract are histologically similar.[7]

Management

For primary treatment of gastrointestinal bleeding, the physician

must stabilize the patient, locate the bleeding site, and stop the acute hemorrhage. In most patients this can be accomplished without resorting to immediate surgery. Acute bleeding secondary to angiodysplasia may be controlled by vasopressin infusion,[20] either in vein or artery. Transcatheter embolization[21] of bleeding arteries has also been suggested for bleeding that has not stopped spontaneously, or after vasopressin infusions. Weaver, *et. al.*,[7] recently described successful endoscopic coagulation in gastric and duodenal angiodysplasia.

To prevent recurrent hemorrhage, patients with angiodysplasia of the gut are frequently treated surgically with removal of the segment of bowel that is bleeding.[8,9,20,22] Several authors have suggested that gastrointestinal bleeding in patients with angiodysplasia of the gut and aortic stenosis may not recur after aortic valve surgery.[5,23,24] Based on this observation, unexplained gastrointestinal bleeding associated with aortic stenosis has been suggested as an indication for aortic valve replacement.[10,24] We describe a patient in whom gastrointestinal bleeding recurred after aortic valve replacement.

Case Report

A 65-year-old man underwent aortic valve replacement and coronary bypass surgery for severe aortic stenosis and coronary artery disease. He had experienced lower gastrointestinal bleeding two years before, and no cause had been found. Six months after surgery, while in the hospital recuperating from suprapubic prostectomy and urinary bladder diverticulectomy, the patient had an episode of bright red rectal bleeding which cleared spontaneously. This bleeding episode was not caused by, or related to, anticoagulant therapy. Work-up, including colonoscopy, did not reveal the cause of the gastrointestinal bleeding. Selective arteriograms were not done. Two years later, gastrointestinal bleeding had not recurred.

Weaver *et. al.*,[7] reported a case showing new or recurrent angiodysplasia after aortic valve replacement. Gastrointestinal bleeding can recur after aortic valve replacement but it may not recur spontaneously for several years without aortic valve surgery.

To expect that aortic valve surgery will relieve recurrent gastrointestinal bleeding due to angiodysplasia, is like expecting that surgery for coarctation of the aorta will correct associated bicuspid aortic valve, or expecting that skeletal abnormalities of Marfan's syndrome will disappear after aortic valve replacement for aortic regurgitation. The problem in angiodysplasia of the gut is in the gastrointestinal tract and that is where treatment should be directed. Aortic valve replacement is not recommended in a patient with aortic stenosis whose only problem is recurrent gastrointestinal bleeding.

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Reference

1. A complete list of references for "Aortic Stenosis and Gastrointestinal Bleeding of Unknown Cause" may be obtained by writing the Illinois Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

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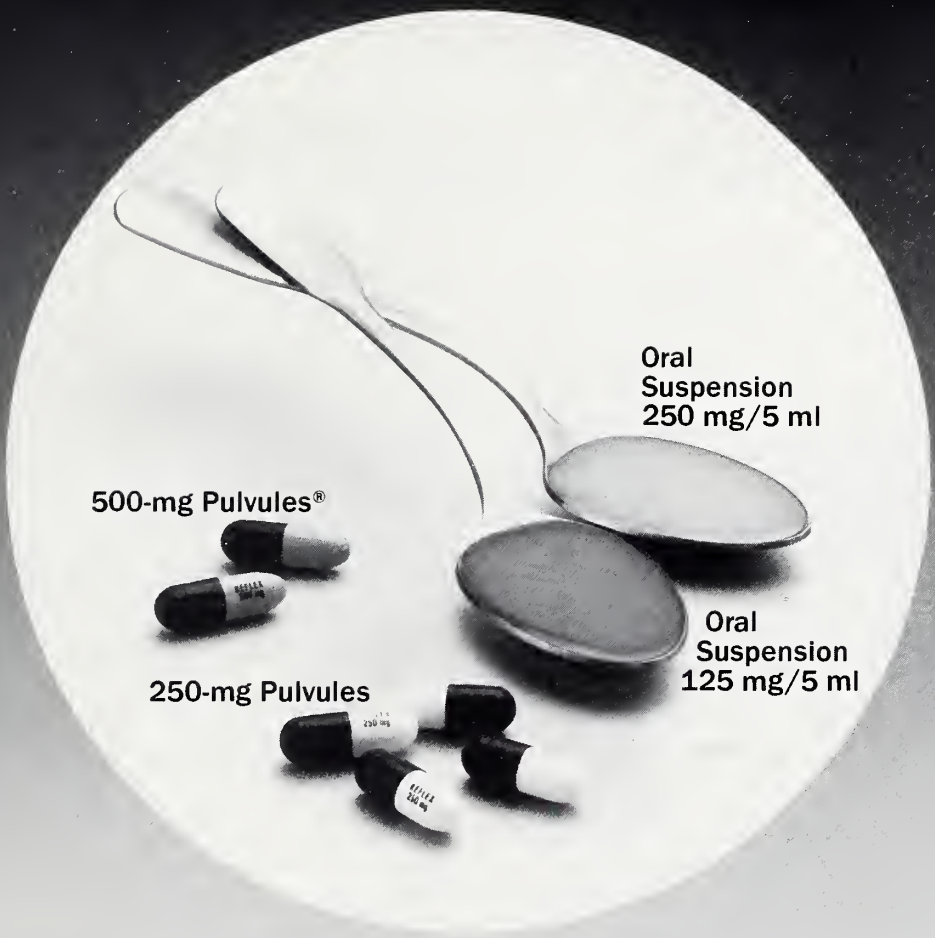
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Doctors and Spouses Care

By Marilyn Leyland (John)/Peoria

Doing good . . . and taking credit for it. Medical societies and their auxiliaries share responsibility for public relations. Particularly when the doctor's good name and sacred honor come under attack, as with the professional liability crisis, it's essential that these groups unite to reassert themselves. Positive public relations brings together medicine's goals and those of the public for mutual understanding.

The public needs to be reminded that doctors and their spouses do care about patients and their health. The generation that remembers going to the doctor's house for care is even older than the one that remembers the doctor's own house calls. The public perception of the doctor's wife had to be different then. She was the one who answered the door even more than the telephone. She probably did a significant share of cleanup after those sick and injured patients who found comfort in her home.

Although some spouses still work in the doctor's office, that role is diminishing as the number of solo practitioners decreases. Answering services and remote paging have also removed the spouse from direct involvement with patients.

Today, it's more important than ever that the public recognize that doctors and their spouses are their advocates. The public still has as much interest in health as in any other subject. That societal interest can only grow as the baby boom generation ages and finds itself in need of more health care services.

Historically, medical auxiliaries have brought the medical community together and have been involved in promoting good health. That role continues today with concern for the needs of the elderly as well as the young, with a continuing "shape up for life" campaign, and with involvement in a wide range of health projects. Such efforts as child abuse education, teen suicide prevention and mammography screening address local needs.

The media needs to be more aware of these involvements. Doctors and their spouses need to initiate and cultivate contact with the news media and establish credibility with reporters from radio, television, newspapers and magazines. In order to reach a large audience, medical societies and auxiliaries must work more closely with these mass media.

In an effort to bring medicine and the media closer together, the Illinois State Medical Society Auxiliary promoted a media day on February 14, 1986. Successfully developed in Florida, the program introduces media representatives and auxiliary members, allowing auxiliaries to showcase programs, provide background, and to thank media representatives for their continuing interest and support.

Each county auxiliary has been encouraged to invite media representatives to a place associated with an auxiliary service project. The event can include a brunch, luncheon, coffee, or other reception. Local initiative is encouraged.

The public needs to know what doctors and their spouses have to say. Now is a good time to get out the message. If you'd like to be involved in a continuing program, please contact your local medical society or auxiliary president or public relations chairman. ◀

RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER

ANNOUNCES

Lithotripsy for Kidney Stone Patients

The Medical Center is pleased to advise the Chicago medical community that its Kidney Stone Treatment Center is accepting patients who can benefit from treatment on the Dornier Extracorporeal Shock Wave Lithotripter, which is now fully operational. Among members of the department of urology already trained and certified in this non-invasive procedure are Malachi J. Flanagan, M.D., Charles F. McKiel, Jr., M.D., and Dennis A. Pessis, M.D.

The protocols established for operation of the lithotripsy program at Rush are designed to keep all referring physicians informed of their patient's progress at all times and to assure that patients are returned to their physician's care upon completion of treatment. We will also provide the physician with a full report, in writing, of the results of treatment.

Certain diagnostic procedures, including x-rays, are required before a patient may undergo lithotripsy. At such time as physicians contact the Kidney Stone Treatment Center to discuss the needs of their patient, they will be advised of what information is needed so that they can make arrangements for appropriate tests. Or, if they prefer, such testing can be done at the Medical Center.

We look forward to serving you and your patients and encourage you to contact the Kidney Stone Treatment Center (312/942-8261) for additional information.

The Kidney Stone Treatment Center
1753 West Congress Parkway Chicago, Illinois 60612



A Good Health Resource of Rush-Presbyterian-St. Luke's Medical Center

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The antihypertensive drugs have reduced the incidences of stroke, congestive heart failure, and the hypertensive complications of the disease process, but have not worked against coronary heart disease and heart attacks. In one study, thiazide diuretics raised cholesterol levels by 6-8%, somewhat ameliorated by strict dietary controls. Triglyceride levels were elevated 20-25% and dietary adherence brought only partial blunting of this effect. Researchers found that beta-blockers raised the triglyceride levels 40% and lowered the high density lipoproteins 10%. (Grimm, R.: *Chicago Med* 89:2, 77-9, 1986)

Outbreaks of Influenza A in two long term care facilities in upstate New York have been reported. Isolated cases of type A and type B influenza viruses were found in Illinois and Minnesota at the end of December and the beginning of January of this year. Arizona, South Carolina and Utah have reported type B. Nationwide, influenza-like illness and reports of deaths associated with pneumonia and influenza from 121 U.S. cities have remained below the levels normally seen with extensive outbreaks. (*Morb & Mort Wkly Rep.* 35:2, 28-9, 1986)

Cerebrovascular accident patients were evaluated as to sexual activities subsequent to the CVA. The mean age of the patients was 68 years. Both sexes had a significant decline in libido, though 84% of men and 60% of women had enjoyed their sex lives before the stroke, contrasted to 30% of males and 31% of women after their CVA. Men had difficulty in achieving an erection and ejaculation and women lacked normal vaginal lubrication and orgasm. One factor elicited was the fear that intercourse would adversely affect the blood pressure and cause another stroke. (Monga, T., *et al: Arch Phys Med Rehabil* 67:1, 19-22, 1986)

The Food and Drug Administration has approved the professional labeling of aspirin to reduce the risk of death and/or non-fatal myocardial infarction in patients with previous infarction or unstable angina pectoris. Studies have indicated a 20% reduction in the risk of subsequent deaths and/or non-fatal reinfarction. In aspirin-treated unstable angina cases, the reduction in risk was approximately 50% over a 12 week study. A conventional 325mg aspirin tablet daily inhibited platelet function adequately and elicited the least adverse reaction. (*FDA Drug Bull.:* 15:4, 34-5, 1985)

A 10 year actuarial survival rate compared two groups of patients treated by coronary bypass surgery. One group received a saphenous vein bypass graft only, and the second group received either an internal mammary artery graft only or a combination of this and a saphenous vein graft. The one vessel graft from the internal mammary artery showed a survival rate of 93.4% as contrasted to an 88% survival rate for the saphenous vein graft group. This disparity increased to a 10% difference in the two vessel and three vessel disease group. An internal mammary artery graft for lesions of the anterior descending coronary artery is preferable whenever indicated and technically feasible. (Loop, F., *et. al: N Engl J Med* 314:1, 1-6, 1986)

Reduction in the cholesterol levels in patients with elevated low-density lipoproteins reduced the risk of myocardial infarction and death. Renal, hepatic, endocrine pathologies or drug-induced secondary causes should be treated initially. If total and LDL cholesterol levels are in 75-90 percentile for age and sex, treat by diet. If the level is in the upper tenth percentile, treat initially with diet and advance to drug treatment as necessary. If plasma LDL cholesterol levels are higher than 600mg, there is a strong family history of hypercholesterolemia, tendon and tuberous xanthoma, treat with diet and drugs. The drugs of choice were cholestyramine resin and colestipol hydrochloride. (Hoeg, J., *et al: JAMA* 255:4, 512-21, 1986)

Pathologic changes in the human testis were analyzed in 31 patients who underwent a vasectomy reversal procedure. This was compared to biopsies in 21 healthy men undergoing vasectomies. Morphometric analysis showed a 100% increase in the thickness of the seminiferous tubular wall, a 50% increase in the mean cross-sectional tubular area, a significant reduction in the number of Sertoli cells and spermatids, and focal interstitial fibrosis in 23% of the specimens. The focal interstitial fibrosis was associated with a high incidence of infertility in those males who undertook vasectomy reversal. (Jarow, J., *et al: N Engl J Med* 313:20, 1252-6, 1985)

The serum thiocyanate levels were studied in cigar and pipe smokers, and compared as to cigarette smoking history. In both of these groups the blood levels were elevated, more markedly in the ex-cigarette smokers because of greater inhalation. Smokers of more than four pipefuls or more than four cigars showed serum thiocyanate levels comparable to that found after subjects had smoked 10 cigarettes. The authors conclude that pipe and cigar smoking should not be substituted for cigarettes, but that cessation of smoking is best. (Pechacek, T., *et al: JAMA* 254:23, 3330-2, 1985)

Thirtieth Annual Convention

By Catherine M. Hill, CMA and Robin Bluestein, CMA-C/Palatine and Chicago

The 30th Annual Meeting of the Illinois Society American Association of Medical Assistants will be hosted by the Aux Plaines Chapter. The theme for this year's meeting is "Through the Looking Glass." The convention will be held at the Hyatt Regency Woodfield located in Schaumburg, Illinois beginning at 5:00 p.m. on Thursday, April 24 and adjourning after a council meeting on Sunday, April 27.

The official convention opening is at 8:00 p.m. on Thursday, with a ribbon cutting ceremony followed by a welcome party where members can meet the candidates.

The 1986 House of Delegates will convene at 9:00 a.m. on Friday, April 25. A number of issues will be brought before the House for discussion and voting. Members will have an opportunity to express their opinions and comments at reference committee hearings during the mid-morning break. Those eligible will vote after those hearings have concluded. The House will reconvene at 2:30 p.m. and adjourn at approximately 5:00 p.m.

The President's Dinner will begin at 7:30 p.m., with Ehlma Garcia, CMA, EMT-A, presiding.

Educational programs will be offered Saturday morning and include the following:

- "A Look Into the Future—MRI," Victor Mategrano, M.D.
- "New Trends in Arthritis Therapy," Gerald Eisenberg, M.D.
- "Through the Looking Glass at You—The Medical Assistant" Barbara Brewe, Ed.D

The annual awards luncheon will also be held on Saturday.

The inaugural banquet for the incoming and outgoing ISMA officers will be held Saturday evening with cocktails at 6:30 p.m. and dinner at 7:30 p.m.

The new executive committee will first meet Sunday at 8:00 a.m. At 9:00 a.m., the farewell breakfast will be presented by the 1987 convention committee, McLean Chapter. Finally, the convention will close with a council meeting at 11:00 a.m.

Throughout the three-day convention, exhibits, arts & crafts, history books, and chapter publications will be on display.

We would also like to express appreciation to the Aux Plaines Chapter for the time and effort devoted to host the 1986 Annual Meeting, and to wish them every success. ◀

Viewbox

(Continued from page 147)

Diagnosis: Chondroblastoma

All of the choices given are benign cartilagenous neoplasms of bone. The age of the patient, symptoms, and radiographic appearance of the lesion, however, are characteristic of chondroblastoma.

Enchondromas are common cartilaginous growths within bone arising from embryonic rests of the epiphyseal cartilage plate. They most often occur in the hands but are found in long bones. However, they seldom occur in the epiphysis prior to epiphyseal closure.

The *osteochondroma* is composed primarily of osseous tissue produced by enchondral ossification of its cartilaginous cap. This tumor develops in bones formed from cartilage. It is the most common benign neoplasm of bone. Location in the epiphysis would be rare.

The *chondromyxoid fibroma* characteristically contains chondroid, fibroid and myxomatous elements, but because certain areas are similar to hyaline cartilage, it is included with tumors of cartilaginous derivation. This is the least common cartilage neoplasm and does not occur in the epiphysis.

Subperiosteal chondromas are rare neoplasms most often found in the hands and feet. They are not epiphyseal lesions.

Chondroblastoma is an uncommon neoplasm which, in long bones, always contacts the epiphyseal plate. Three-fourths occur in the second decade. Mild pain is common. The radiographic appearance is usually characteristic: a well defined lucency in contact with the epiphyseal plate.

Chondroblastoma

The chondroblastoma was categorized initially as a "giant cell tumor" by Kolodny in 1927, and as a "calcifying giant cell tumor" by Ewing in 1928.[1] In 1931, Codman noted nine cases which he thought were variants of giant cell tumors and referred to them as "epiphyseal chondromatous giant cell lesions."[2] It was not until 1942 that Jaffe and Lichtenstein described this lesion in detail and designated the name benign chondroblastoma.[3]

Incidence

Chondroblastoma comprises less than one percent of all bone tumors. Patients usually present with pain and local swelling of several months to a year in duration. Swelling is noted in 10% of the cases. Pathologic fracture is rare. Lesions have been found in young children and the elderly, but 90% of the patients are 5-25 years old and 65% present in the second decade. A male to female ratio of 2:1 has been noted. Patients presenting in older age groups tend to have lesions in flat bones.[4-6]

Pathology

Chondroblastomas were at one time incorrectly felt to have reticuloendothelial origin. They actually arise from cartilaginous germ cells derived from the epiphysis. This origin is substantiated by electron microscopy studies.[4,6] Rare chondroblastomas in the skull, however, cannot be explained by this mechanism. The epiphyseal region of long bones is primarily affected. In descending order of frequency, the proximal femur, proximal tibia, distal femur, proximal humerus, tarsal and innominate bones are the most common locations. An apophysis, such as a femoral trochanter, can also be a site of origin. Grossly, the tumor is similar to granulation tissue. It is red to gray with flecks of gritty calcific material or blue-gray cartilaginous fragments. Focal regions of hemorrhage, necrotic tissue and cyst formation can also be present.

Chondroblastomas usually contain compact round or polygonal cells with large nuclei. These cells are separated by islands of chondroid matrix. Rarely is more than 50% composed of chondroid matrix. Calcification occurs in a "chicken-wire" pattern in which calcium is deposited in a lattice-like configuration pericellularly. Nodular focal calcification can also be seen. The degree of calcification tends to be proportional to the degree of cell degeneration and tissue necrosis. In later phases, the necrotic tissue can be replaced by connective tissue making differentiation from chondromyxoid fibroma difficult. Transformation of cartilage into osteoid and bone can make this lesion difficult to distinguish from osteoblastoma. In 20-25% aneurysmally dilated blood vessels are present, which increases the chance of recurrence. This microscopically resembles an aneurysmal bone cyst and is termed a cystic chondroblastoma.[3,4]

Radiology

The tumor is usually a well defined oval lytic lesion confined to an epiphysis while the growth plate is still open. It may extend to or be in the metaphysis. Tumors are usually less than 4cm in diameter and eccentric in location. Flocculent calcific densities are seen in about 50% of tumors. The osteolytic defect is often delineated by a thin sclerotic rim which separates it from normal bone. As growth progresses, the rim becomes thickened and mottled, while fluffy calcifications are located centrally. Occasionally there is periosteal new bone formation or a fuzzy border.[4-6]

Treatment and Prognosis

Several cases in the literature indicate a malignant or aggressive potential of chondroblastomas.[7-12] Accounts of infiltration into adjacent soft tissues after curettage probably represent surgical implantation or direct contiguous spread. Cases of transarticular curettage have resulted in synovial membrane and articular recurrences.

Several cases of benign chondroblastoma with metastases to the lung have been reported.[7,11] These pulmonary lesions are usually nonprogressive and have been attributed to a transport phenomenum related to surgical intervention. Sweetnam and Ross described a case with a solitary lung metastasis which was treated with lobectomy, but there was no histologic documentation.[11] Hatcher and Campbell describe chondrosarcomatous degeneration in a chondoblastoma, but the patient had received 3600 rads of radiation.[12] Radia-

tion-induced transformation has been documented by others. Chondroblastomas can be histologically mistaken for chondrosarcoma.[3-6] Although primary malignant chondroblastoma may exist, it is very rare.

The most common treatment of these neoplasms is curettage with replacement of the bony defect with bone chips. A recurrence rate in one series of 50 patients was about 15%. The recurrence rate has been reported to be higher when the chondroblastoma is associated with an aneurysmal bone cyst. Cryosurgery has been reported to produce a lower recurrence rate than curettage.[6]

References

1. Kolodny, A.: "Bone Sarcoma. The Primary Malignant Tumors of Bone and the Giant Cell Tumor," *Surg Gynecol Obstet* 44(Supplement):172-214, 1927.
2. Codman, E.A.: "Epiphyseal Chondromatous Giant Cell Tumors of the Upper End of the Humerus," *Surg Gynecol Obstet* 52:543-548, 1931.
3. Jaffe, H.L., Lichtenstein, L.: "Benign Chondroblastoma of Bone. A Reinterpretation of the So-Called Calcifying or Chondromatous Giant Cell Tumor," *Am J Path* 18:969, 1942.
4. Dahlin, D., Ivin, J.C.: "Benign Chondroblastoma. A Study of 125 Cases," *Cancer* 30(2):401-413, 1972.
5. Dahlin, D.: Bone Tumors: General Aspects and Data of 6221 Cases. 3rd ed., Thomas, C.C., Springfield, Ill., 1978.
6. Bloem, J.L., Mulder, J.D.: "Chondroblastoma: A Clinical and Radiological Study of 104 Cases," *Skeletal Radiol* 14:1-9, 1985.
7. Green, P., *et al.*: "Benign Chondroblastoma. Case Report with Pulmonary Metastasis," *J Bone & Joint Surg* 57A(3):418-419, 1975.
8. Kahn, G.B., Wood, F.M., Ackerman, L.V.: "Malignant Chondroblastoma. Report of Two Cases and Review of the Literature," *Arch Path* 88:371-376, 1969.
9. Mirra, J.M., *et al.*: "Aggressive Chondroblastoma. Light and Ultramicroscopic Findings After En Bloc Resection," *Clin Orthop* 178:276-284, 1983.
10. Wirmon, J.A., *et al.* "Metastatic Chondroblastoma. Report of an Unusual Case Treated with Radiotherapy," *Cancer* 44:87-93, 1979.
11. Sweetnam, R., Ross, L.: "Surgical Treatment of Pulmonary Metastases From Primary Tumors of Bone," *J Bone Joint Surg* 49:74-79, 1967.
12. Hatcher, C.H., Campbell, J.C.: "Benign Chondroblastoma of Bone: Its Histologic Variations and a Report of Late Sarcoma in the Site of One," *Bull Hosp Joint Dis* 12:411, 1951.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education (DRE)

Disciplinary Orders

- *Mohammad Asghar* (lic.# 036-54415)
  On December 24, 1985, Dr. Asghar's medical license was reprimanded and placed on a one year probation.
- *Jerry L. Beguelin* (lic.# 036-38738)
  Effective December 24, 1985, the medical license of Dr. Beguelin was reprimanded and placed on a one year probation.
- *Lothar Hussman* (lic.# 036-30870)
  Effective September 13, 1985, Dr. Hussman voluntarily surrendered his medical license for indefinite suspension.
- *Belmont Kappmeyer* (lic.# 036-21447 & 003-036-21447)
  On December 12, 1985, an order was signed which resulted in Dr. Kappmeyer's medical and controlled substance licenses to be surrendered and placed on Inactive Status.
- *Joseph R. Mejia* (lic.# 036-59796)
  Effective September 19, 1985, the medical license of Dr. Mejia was suspended for one year, but the suspension was stayed and the physician was placed on probation for one year.
- *James G. O'Donnell* (lic.# 036-54257)
  Effective August 9, 1985, Dr. O'Donnell's medical license was suspended.
- *Robert R. Roth* (lic.# 036-25157)
  Effective December 24, 1985, Dr. Roth's medical license was placed on probation for 2 years, subject to certain conditions.
- *Eustaquio S. Vallejo* (lic.# 036-47132 & 003-036-47132)
  Effective December 12, 1985, Dr. Vallejo's medical and controlled substance licenses were reprimanded.
- *Irving Weissman* (lic.# 036-27439 & 003-036-27439-1)
  Effective December 12, 1985, Dr. Weissman's medical and controlled substance licenses were revoked.
- *Clyde Wieland* (lic.# 036-34319)
  On December 16, 1985, Dr. Wieland's medical license was suspended, but the suspension was stayed and the physician was placed on a 2-year probation.
  (Source: Orders received by ISMS which have been signed by the Director of DRE)

From the Department of Public Health (IDPH)

Rubella Vaccine Recommendations

The IDPH Medical Determinations Board has recommended that the state accept children who have had a rubella vaccination a few days before their first birthday as having met the school entrance immunizations requirements. IDPH communicable disease staff reported that rubella vaccine has not been shown to lose effectiveness when given at an early stage in life.

Pertussis Vaccine Recommendations

The Medical Determinations Board also adopted IDPH recommendations that a child who received a DT pre-school booster during the recent DPT shortage should be considered in compliance with state rules requiring DPT for one year following the date of the booster. After the year, a DPT shot should be given, unless the child is age six or older. IDPH communicable disease staff reported that pertussis vaccine is not required after six years of age, and the frequency of reactions to the vaccine would increase if DPT were given soon after a child received a DT shot.

HTLV-III Antibody Test Sites

IDPH has announced that all local health departments have been invited to operate alternative test sites to provide counseling and HTLV-III antibody tests for interested persons. Ten to twenty sites are expected to

be established around the state. The alternative sites will offer the HTLV-III antibody test in conjunction with counseling and other educational efforts for the public, and particularly those in identified high-risk groups. The purpose of establishing these sites is to divert high-risk individuals from going to blood banks to receive the HTLV-III antibody test. Beginning January 3, 1986, blood banks were permitted to notify Western blot-positive donors of their results.

HTLV-III Antibody Testing for Physician Offices

The IDPH state laboratory will now provide free ELISA and, if appropriate, Western blot tests, for specimens sent in from private physician offices. In addition, literature on AIDS and the HTLV-III tests will be sent to physicians by the state.

The physician's office or a private laboratory will have to centrifuge the blood specimen to separate the serum from the red blood cells for submission to the state laboratory. Physicians should contact the IDPH state lab at 2121 W. Taylor, Chicago 60612, for containers in which to ship the specimens.
(Source: December 13, 1985 meeting of the Medical Determinations Board) ◀

Prescription for Doctors

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BOX 270 I
SIOUX NARROWS, ONT, POX INO
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EKG

(Continued from page 155)

Answers: 1. A, C, D. 2. A, B, C, E.

The first ECG shows an irregularly irregular rhythm without P waves. This is atrial fibrillation. No ventricular tachycardia is present. The apparent distortion of the QRS in the first ECG is due to a marked ST segment elevation or current of injury. The ST segment elevation in leads II, III, and AVF suggests a hyperacute inferior wall myocardial infarction. The reciprocal of this ST segment elevation is the marked ST segment depression seen in leads I, AVL, and all across the precordium, leads V_1 to V_6. This marked ST segment depression or reciprocal current of injury suggests that a large area of the inferior, posterior, apical, and lateral walls of the left ventricle is in jeopardy. This developed in our patient following a history of gradually worsening angina, *i.e.,* increasing in frequency and from exercise to rest. This worsening or unstable angina could be called preinfarction angina, since it was followed by a hyperacute myocardial infarction.

In this early period after the onset of the pain of acute myocardial infarction, intravenous streptokinase may lyse the thrombus and interrupt the acute infarction sequence. Emergency coronary angiography could best define the anatomy here. On the way to the angiography laboratory, our patient had ventricular fibrillation and needed emergency direct cardioversion. The second ECG was obtained after his resuscitation. The coronary angiogram showed non-obstructive coronary lesions in the left coronary system. The native right coronary artery was totally occluded. Flow to the distal large right coronary artery came by way of an aortacoronary bypass graft. It was a large artery supplying the inferior, lateral, and apical myocardium. The aortacoronary bypass graft was subtotally occluded at the site of the anastomosis with the right coronary artery. An angioplasty catheter was carefully passed across the obstructed anastomotic site. The pressure proximal to the obstruction was 120/60mmHg, and distal to the subtotal obstruction it was 60/40mmHg. After successful balloon angioplasty of this anastomotic obstruction, the proximal and distal pressures were 110/70 and 100/70mmHg respectively. Although streptokinase may lyse a thrombus in coronary artery disease, it will have no effect on the obstructive subintimal coronary disease. Moreover, the thrombus may recur unless a more definitive procedure, such as coronary angioplasty, is performed. Beta blockade by any of the available agents would tend to depress ventricular function further. The patient had bibasilar rales on examination of the lungs on admission, and later became hypotensive. Although beta blockade was therefore not indicated, reperfusion of the large right coronary artery with streptokinase and coronary angioplasty improved myocardial function greatly. Postangioplasty, the blood pressure stabilized and the pulmonary rales disappeared. The patient continued on a stable course and was discharged from the hospital.

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

APRIL

Allergy

The Relationship of Respiratory Infections to Asthma
For: Physicians. Lecture (dinner meeting), April 21, 6:00 p.m., Chicago, IL. **Sponsor:** The Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane K. Kubis. **Phone:** (312) 255-1024.

Ophthalmology

8th Annual Midwest Claucoma Symposium
For: Ophthalmologists. Symposium, April 11-12, 8:30 a.m.-5:30 p.m., Chicago, IL. **Sponsor:** The University of Illinois College of Medicine at Chicago, Department of Ophthalmology, and Northwestern University. **Fee:** $225 for physicians, $100 for residents. **Reg. Deadline:** March 28. **Reg. Limit:** 250. **Credit:** Category 1: 12 hours. **Contact:** Sue Korienek, The University of Illinois at Chicago, Conferences and Institutes, 912 S. Wood St., 2N, Chicago, IL 60612. **Phone:** (312) 996-8025.

10th Annual Ophthalmology Current Concepts Seminar '86
For: Ophthalmologists. Conference, April 10-12, Madison, WI. **Sponsors:** University of Wisconsin-Madison, Department of Ophthalmology, and School of Medicine, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: approx. 18 hours; University of Wisconsin CEU's: approx. 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Emergency Medicine

Illinois ACEP 1986 Scientific Assembly
For: Emergency physicians, nurses, paramedics, pediatricians and family practice physicians. April 11-13, The Hamilton Hotel, Itasca, IL. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Fee:** $90-$250. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Advanced Trauma Life Support Provider Course
For: Physicians. Symposium, April 2-3, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Fee:** $35 **Reg. Limit:** None. **Credit:** To be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Neurology/Biology/Basic Sciences

Ninth Annual Midwest Neurobiology Meeting
For: Physicians. Symposium, April 4-6, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Fee:** $35. **Reg. Limit:** None. **Credit:** To be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Gynecology

Current Management of Problems in Cynecology and Cynecologic Urology
For: Ob-Cyn's. Course, April 11-12, Knickerbocker Hotel, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $225. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, ACOG: 10 Cognates. **Contact:** Marlene Goldberg, **Phone:** (312) 962-1056.

Office Obstetrical Management: Risks and Benefits
For: Physicians and other health professionals. Conference, April 15-16, Madison, WI. **Sponsors:** University of Wisconsin-Madison-CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705; and departments of OB/CYN, pediatrics and family practice, School of Medicine, University of Wisconsin-Madison; Madison General Hospital. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; University of Wisconsin CEU's: 10 hours; AAFP Prescribed: Credit pending, approx. 10 hours; AOA Category 2-D: credit pending. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Specialty Review in Obstetrics and Cynecology
For: Obstetricians and gynecologists. Lecture, April 28-May 3, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $670. **Reg. Limit:** None. **Credit:** Category 1: 54 hours; ACOG: 53 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4641.

Surgery, Hospital Administration

Outpatient Surgery Symposium: Administration and Clinical Applications
For: Physicians and other health professionals. Conference, April 25, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME and School of Medicine, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** to be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Elective: 7 hours; and University of Wisconsin CEU's: 7 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Family Medicine/Psychiatry/Cardiology

The Brain and the Heart: Inter-Relation in Psychiatric and Cardiac Patient Management
For: Family and general practitioners, psychiatrists, cardiologists, and internists. Conference, April 5, Omni International Hotel, St. Louis, MO. **Sponsor:** St. Louis, University School of Medicine, 1402 South Grand Blvd., St. Louis, MO 63104. **Fee:** $50. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Otolaryngology

Surgery of the Paranasal Sinuses
For: Otolaryngologists, head and neck surgeons. Workshop with lab, April 21-23, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, 1402 South Grand Blvd., St. Louis, MO 63104. **Fee:** $500. **Reg. Limit:** 40. **Credit:** Category 1: 24 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Physical Medicine/Neurology/Urology

Sexual Dysfunction in the Neurologically Impaired—An Update
For: Psychiatrists, neurologists and urologists. Course, April 4-5, 8:00 a.m.-4:00 p.m., Hines V.A. Hospital, Hines, IL. **Sponsor:** Hines VA Hospital and Urology Department of Loyola. **Fee:** $100 (includes lunch). **Reg. Limit:** 100. **Reg. Deadline:** March 28. **Credit:** Category 1: 11 hours. **Contact:** Jay Subbarao, M.D. **Phone:** (312) 343-3878.

Surgery

Fiberoptic Colonoscopy
For: Eligible or board certified surgeons and internists. Lecture, April 9-11, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1: 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Fiberoptic Esophagogastric Endoscopy
For: Eligible or board certified surgeons and internists. Lecture, April 14-16, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1: 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Urology

Specialty Review in Urology
For: Urologists. Lecture, April 14-19, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $680. **Reg. Limit:** None. **Credit:** Category 1: 53 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Emergency Medicine

Advances in Emergency Medicine, 1986
For: Emergency medicine physicians. Lecture, April 28-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $335. **Reg. Limit:** 90. **Credit:** Category 1: 25 hours; AAFP Prescribed: 24 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Family Medicine

Environmental Diseases of Clinical Importance
For: Primary care physicians, pulmonary disease specialists and forensic pathologists. Lecture, April 16-18, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $335. **Reg. Limit:** 90. **Credit:** Category 1: 24 hours; AAFP Prescribed: 23 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Cleft Lip/Palate

Cleft Lip and Palate: A 1986 Perspective
For: Physicians. Course, April 4-5, 9:00 a.m.-4:00 p.m., Chicago, IL. **Sponsor:** Center for Craniofacial Anomalies, University of Illinois at Chicago, P.O. Box 6998, Chicago, IL 60612. **Fee:** $150 for physicians and $100 residents/students. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marcia Aduss at above address.

Pediatrics/Family Medicine

Contemporary Pediatrics for the Practicing Physician
For: Pediatricians and family physicians. Course, April 18-19, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg, Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, **AAFP Prescribed:** 10 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Internal Medicine/Family Medicine

Aggressive Management of Diabetes and Obesity
For: General internists and family physicians. Course, April 11-12, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 11 hours. **AAFP Prescribed:** 11 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Clinical Endocrinology for 1986
For: Family practitioners. Symposium, April 5, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $60. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Neurovascular

Management Strategies in Medicine
For: Neurovascular and interested physicians. April 17, afternoon session-3:45 to 5:00 P.M.; evening session 6:00 P.M., Downtown Hyatt Hotel, Chicago. **Sponsor:** Neurovascular Society of North America, P.O. Box 679, Oak Park, IL 60303. **Fee:** $175 (members); $225 (non-members). **Credit:** Category 1. **Contact:** Andrew Carney, M.D. **Phone:** (312) 482-3950.

Intracranial Doppler and Brain Hemodynamics
For: Neurovascular and interested physicians. April 17, 8:00 a.m., Downtown Hyatt Hotel. **Sponsor:** Neurovascular Society of North America, P.O. Box 679, Oak Park, IL 60303. **Fee:** $175 (members); $225 (non-members). **Credit:** Category 1. **Contact:** Andrew Carney, M.D. **Phone:** (312) 482-3950.

Organization of Neurovascular Laboratory
For: Neurovascular and interested physicians. April 19, 1:00 p.m., Downtown Hyatt Hotel. **Sponsor:** Neurovascular Society of North America, P.O. Box 679, Oak Park, IL 60303. **Fee:** $85 per course (members); $100 per course (non-members). **Credit:** Category 1. **Contact:** Andrew Carney, M.D. **Phone:** (312) 482-3950.

Headache and Neurovascular Surgery
For: Neurovascular and interested physicians. April 19, 8:00 a.m., Downtown Hyatt Hotel. **Sponsor:** Neurovascular Society of North America, P.O. Box 679, Oak Park, IL 60303. **Fee:** $85 per course (members); $100 per course (non-members). **Credit:** Category 1. **Contact:** Andrew Carney, M.D. **Phone:** (312) 482-3950.

Vertebral Artery Surgery
For: Neurovascular and interested physicians. April 19, 8:00 a.m. and 1:00 p.m., Downtown Hyatt Hotel. **Sponsor:** Neurovascular Society of North America, P.O. Box 679, Oak Park, IL 60303. **Fee:** $85 per course (members); $100 per course (non-members). **Credit:** Category 1. **Contact:** Andrew Carney, M.D. **Phone:** (312) 482-3950.

MAY

Allergy

Resident-Fellow Abstact Presentation
For: Allergists. May 19, 6:00 (cocktails), 7:00 (dinner), 8:00 p.m. (meeting), Holiday City Centre, Chicago, IL. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1.5 hours. **Contact:** Dianne K. Kubis. **Phone:** (312) 255-1024.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, May 16-18, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category I: 16.5 hours. **Contact:** Mary Ann Dillon. **Phone:** (312) 962-1056.

Pediatrics/Neurology

Medical Seminar-at-Sea (Fjords)
For: Physicians. Symposium, May 17-28, British Isles/Ireland/Norway. **Sponsor:** Southern Illinois University School of Medicine, CME, P.O. Box 3926, Springfield, IL 62708. **Fee:** $500. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine

17th Family Medicine Review
For: Family Physicians. Course, May 18-23, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $425 ($450 after 5/2). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP Elective: 50 hours. **Contact:** Rosemary Fisher. **Phone:** (606) 233-5264.

2nd Annual Conference on Controversies in Family Medicine: Who Pays When the Safety Net Fails?
For: Physicians and other health professionals. Conference, May 1-2, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Department of Family Medicine, University of Wisconsin, 465B WARF Bldg., 620 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA Category 2-D and University of Wisconsin CEU's: 13 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Sports Medicine/Orthopedics

2nd Annual Sports Medicine Symposium
For: Physicians and other health professionals. Conference, May 16-17, Madison, WI. **Sponsors:** University of Wisconsin-Madison, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Division of Orthopedic Medicine, University of Wisconsin Hospital, Sports Medicine and Fitness Center. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; AAFP credit pending; AOA Category 2-D, and University of Wisconsin CEUs: 11. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

JUNE

OB/GYN/Family Medicine

Update in OB/GYN
For: OB/Gyn and family physicians. Course, June 13-14, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, Office of Continuing Education, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP: 10. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

OB/GYN/Family Medicine/Urology

Medical Seminar-at-Sea (North Cape Cruise)
For: Interested physicians. June 21-July 3, North Cape. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $500. **Credit:** Category 1: 48 hours. **Contact:** Charles Osborne, Ed.D.. **Phone:** (217) 782-7711.

Chicago Area Schools of Medicine Obstetrics and Gynecology Review
For: OB/Gyn's. Course, June 16-21, Chicago, IL. **Sponsors:** Seven medical schools of Illinois, c/o The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $550. **Reg. Limit:** None. **Credit:** Category 1: 42 hours; ACOG: 42 Cognates. **Contact:** Mary Ann Dillon. **Phone:** (312) 926-1056.

Otolaryngology

Chicago Temporal Bone Dissection Course
For: Otolaryngologists/residents. Course, June 2-6, Hinsdale, IL. **Sponsors:** Department of Otolaryngology for Northwestern, Loyola and Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521. **Fee:** $900 (physicians), $600 (residents). **Reg. Limit:** 8. **Credit:** Category 1: 40 hours. **Contact:** Cheri Jones, M.P.H. **Phone:** (312) 887-2400.

PHYSICIAN'S RECOGNITION AWARD

The American Medical Association understands how valuable your time is. We know there aren't enough hours in the day for doctors to do everything they want to do for their patients, community, family, friends, and themselves.

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POSITIONS AND PRACTICE

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Allison Katz, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

FAMILY PRACTITIONER/INTERNAL Medicine—To locate in Rosiclare, Illinois. 48 bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. Contact Roby Williams, Administrator, PO Box 467, Rosiclare, IL 62982. (618) 285-6634.

ARIZONA BASED Physician recruitment firm has opportunities coast to coast. "Professionals working with Professionals." Over 13 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

HEALTHLINE PHYSICIAN SERVICES, An affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency departments, clinics and locum tenums work. Healthline offers excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman at Healthline Physician Services, 8401 Hanley Industrial Court, St. Louis, MO 63144; (314) 962-1233.

FAMILY PRACTICE/Internal Medicine—Central Illinois. Various opportunities available: solo and group. Reply to Box 1186, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

PRIVATE PRACTICE Opportunities: Internal Medicine, family practice- OB/GYN- pediatrics. Guaranteed income-no capital investment. Affiliated with major university. Call (314) 652-8310.

OPHTHALMOLOGIST, ILLINOIS: Locum tenens. Start immediately. High income, high volume general ophthalmology practice. Owner needs help. Assist surgery and patients. Housing available. Possible future career opportunity. Write Box #1191, c/o, *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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ALLERGIST—ABAI certified/eligible via pediatrics or medicine wanted part-time or full-time in suburban Chicago allergy practice (multiple HMO/PPO/private patient mixture). Reply to Box #1196, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CARDIOLOGIST. Excellent opportunity for a board certified or eligible cardiologist to associate with a progressive cardiology group in north central Wisconsin. Modern single community hospital offering all varieties of comprehensive cardiology and cardiovascular/thoracic surgery services. Position available now. If interested, send C.V. to and/or contact D. Joe Freeman, MD, FACC, North Central Heart Clinic, 425 Pine Ridge Blvd., Suite 204, Wausau, Wisconsin 54401; (715) 845-NCHC (6242).

RHEUMATOLOGY. Lucrative practice opening in association with dynamic growth-oriented 234-bed hospital. Studies of the area document the need for this search which also has the full support of the medical staff. Space has been reserved in the new professional office building adjoining the completely rebuilt hospital. Competitive financial guarantees and good coverage are available. Quality lifestyle in community of 40,000 within a metropolitan area of 350,000, offers the best of country and city living. Medical school and several colleges within 15 minutes. Immediate access to cultural and outstanding recreational activities. Call (collect) Karlman Associates (415) 775-1657.

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EMERGENCY MEDICINE—Illinois: Excellent emergency medicine opportunities are available at select client hospitals located in central Illinois. Interviews are being arranged for full-time positions. Part-time opportunities are also available. Flexible scheduling, guaranteed competitive income, and occurrence malpractice coverage. For details contact Tom Baldwin, Spectrum Emergency Care, Inc., P.O. Box 27352, St.

Louis, MO 63141; 1 (800) 325-3982; (314) 878-2280.

PHYSICIANS! CENTRAL CA. FT directorship, emerg. rm. low vol, malpractice provided. Rural area, 2 hrs SE of San Francisco, near Yosemite Natl Pk, Monterey/Carmel. Must relocate. Other FT/PT Oppor. in CA, AZ, WA, N.M. Call: National Emergency Services (800) 554-4405 (US) or (800) 356-5225 (CA only).

INTERNAL MEDICINE. Lucrative practice opening in association with dynamic growth-oriented 234-bed hospital. Studies of the area document the need for this search which also has the full support of the medical staff. Space has been reserved in the new professional office building adjoining the completely rebuilt hospital. Competitive financial guarantees and good coverage are available. Quality lifestyle in community of 40,000 within a metropolitan area of 350,000, offers the best of country and city living. Medical school and several colleges within 15 minutes. Immediate access to cultural and outstanding recreational activities. Call (collect) Karlman Associates (415) 775-1657.

EMERGENCY PHYSICIANS: Professionally-oriented emergency physician group has immediate full-time opportunities for board-prepared emergency physician in northwest Chicago suburb. Respond with C.V. to: Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Bldg. C, Plantation, FL 33322, or call (305) 472-6922.

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RADIOLOGY—Locums, complete coverage, 10 years experience. Write to Box #2000, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

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TRANXENE®
(clorazepate dipotassium) ©

Brief Summary of Prescribing Information

INDICATIONS – For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS – Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS – Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS – Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS – Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS – Potentiation may occur with ethyl alcohol, hypnotics, barbituates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE – Take general measures as for any CNS depressant.

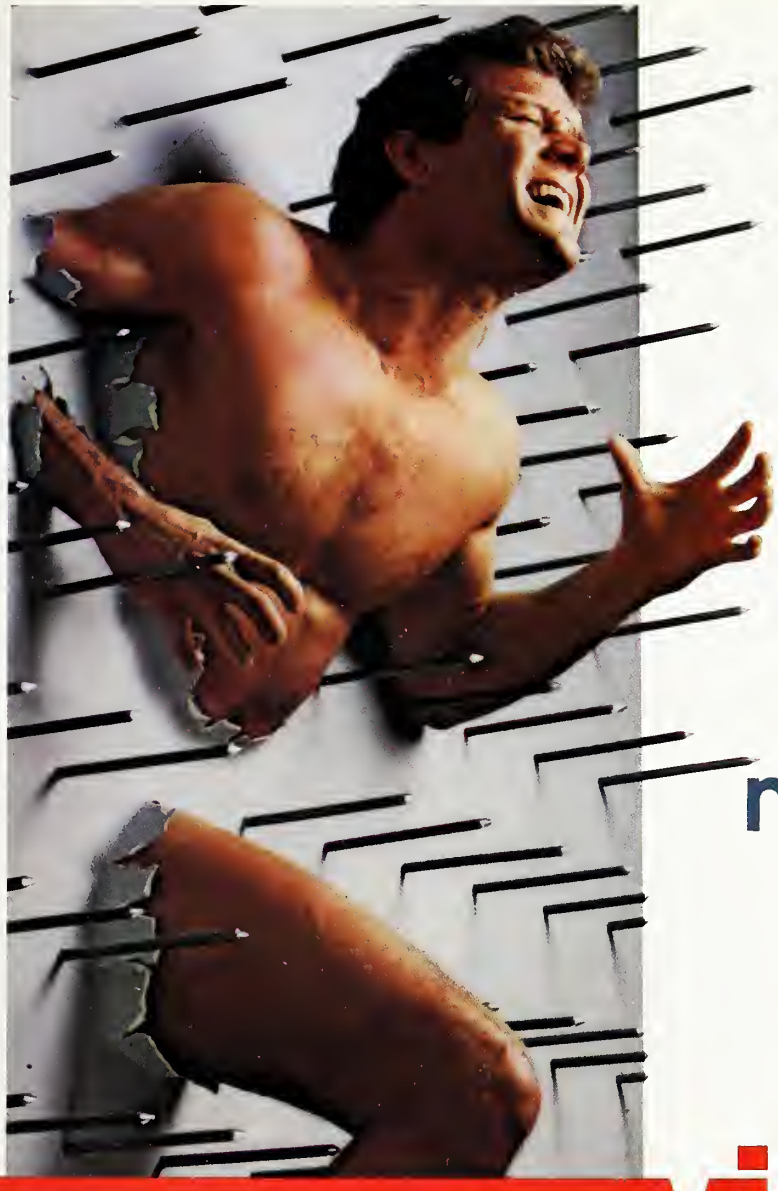
SUPPLIED – TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCES:

1. Dureman I, Malmgren H, Norrman B: Comparison studies of chlorazepate [*sic*] administered as a divided daily dose and as a single dose at night. *Psychopharmacology* 57:123-126, 1978.
2. Healey M, Pickens R, Meisch R, et al: Effects of clorazepate, diazepam, lorazepam, and placebo on human memory. *J Clin Psychiatry* 44:436-439, 1983.
3. Scharf MB, Khosla N, Brocker N, et al: Differential amnestic properties of short- and long-acting benzodiazepines. *J Clin Psychiatry* 45:51-53, 1984.

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North Chicago, IL 60064



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982

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30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

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February, 1985

Perhaps Not the Oldest But Clearly the Best



As I assume the role of spokesman for the Illinois State Medical Society, I would like to thank my county medical society caucus for nominating me, and the House of Delegates for electing me, to the office of president-elect last April. I promise to work hard to justify their trust.

Before going on, I feel it would be more than appropriate to thank the two past presidents, Drs. Hamilton and Meyer, and the chairman of the board, Dr. Clementi, along with the Board of Trustees for the excellent progress that has been achieved in the last two years.

Each year the House of Delegates elects a new president, someone who will bring his own style to the office, but will ask for help from the membership to achieve whatever has to be done.

No state medical society can succeed unless the membership enthusiastically supports the policies and projects that have been espoused by their elected representatives. During the coming year, as I make the "President's Tour," I will be looking forward to meeting many of you. I look forward to your input on problems and concerns that can be addressed by organized medicine. I may also be asking for your help in whatever support is needed in the coming year.

Starting a new year is like driving a brand new car for the first time. You worry about the inevitable first dent in that clean, new surface. I am sure we will suffer our dents in the next year. But I am equally confident that ISMS will always be strong enough to stay on course. That course may not always be smooth, but we will not be deterred and we will never break.

This year we will continue our efforts to achieve significant tort reform. This will be a high priority. We will continue to work for an improved medical disciplinary system. Your leadership will also continue to seek legislation that would allow the state medical society to help physicians work together to share information and find solutions when contract proposals are being considered.

If you keep on saying things are going to be bad, you have a good chance of becoming a prophet. Let's be upbeat and optimistic this year. Medicine may not be the world's oldest profession, but it is clearly the best. ◀

Jere E. Freidheim, M.D.
President



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Anxiolytic therapy affects more than just the patient...think of the people who rely on your patient every day. TRANXENE® provides effective relief of anxiety symptoms, but without overpowering your patient's ability to function normally. Studies comparing Tranxene and placebo have shown no reduction in perceptual wakefulness or fine motor skills,[1*] as well as no significant memory deficit in normal subjects after acute administration.[2,3]

*As with all benzodiazepines, patients should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery, including motor vehicles.

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TRANXENE®
(clorazepate dipotassium) ℂ

TRANXENE®
(clorazepate dipotassium) C-IV

Brief Summary of Prescribing Information

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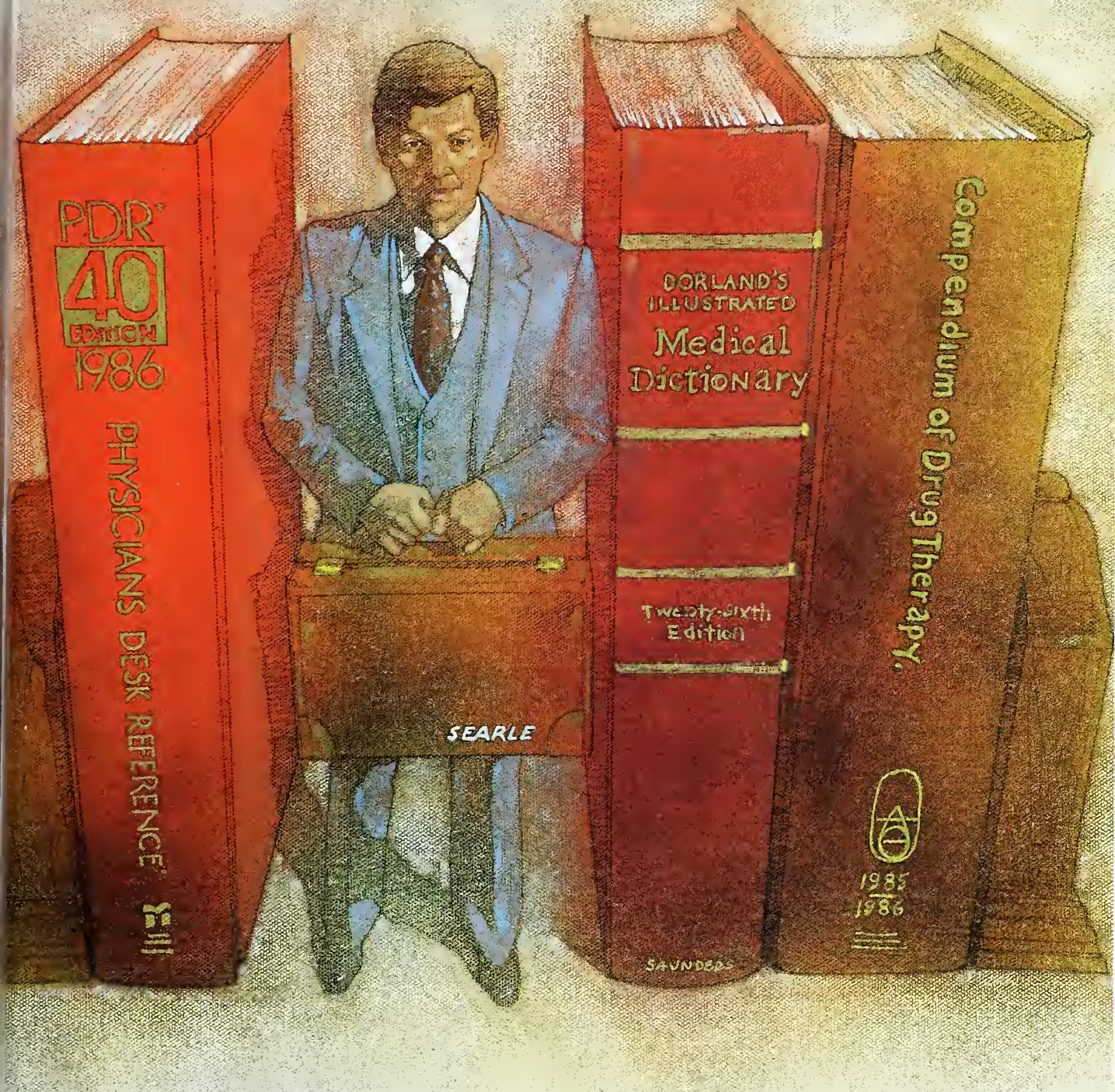
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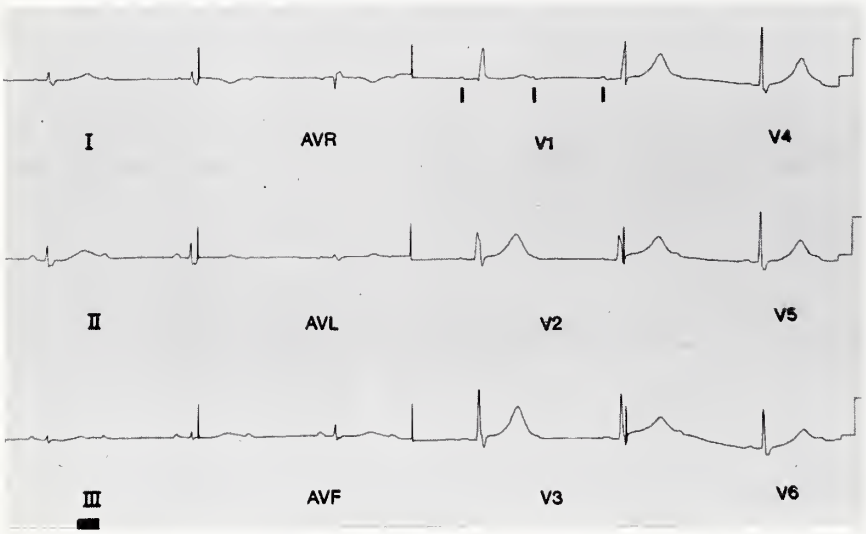
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is an 81-year-old man with a 20 year history of insulin dependent diabetes. His only complaint on routine visit was slightly increased tiredness in the past two months. He had no history of cardiac disease and specifically denied chest pain, palpitations, dyspnea, orthopnea, pedal edema, or syncope. His wife reported that he also had a problem with nocturia and occasional urinary incontinence.

Physical exam showed a pulse of 36 beats per minute and a blood pressure of 135/70mmHg. Aside from a slow rate, the cardiac exam was normal. Lungs were clear and the rest of the physical exam was normal. A chest x-ray revealed a normal cardiac silhouette, chronic interstitial changes in both lung fields, a calcified nodule unchanged for three years, and degenerative changes in the spine. A three-year-old electrocardiogram showed complete left bundle branch block. This twelve lead ECG was recorded.

Questions:

1. This twelve lead ECG shows:
   a. Complete left bundle branch block.
   b. Complete right bundle branch block.
   c. Left anterior hemiblock.
   d. First degree atrioventricular (AV) block.
   e. Second degree AV block.

2. Appropriate treatment measure could include:
   a. Cardiac catheterization and coronary angiography.
   b. Admission to the telemetry unit for ECG monitoring.
   c. Electrophysiology study.
   d. Permanent pacemaker.
   e. All of the above.

(Continued on page 204)

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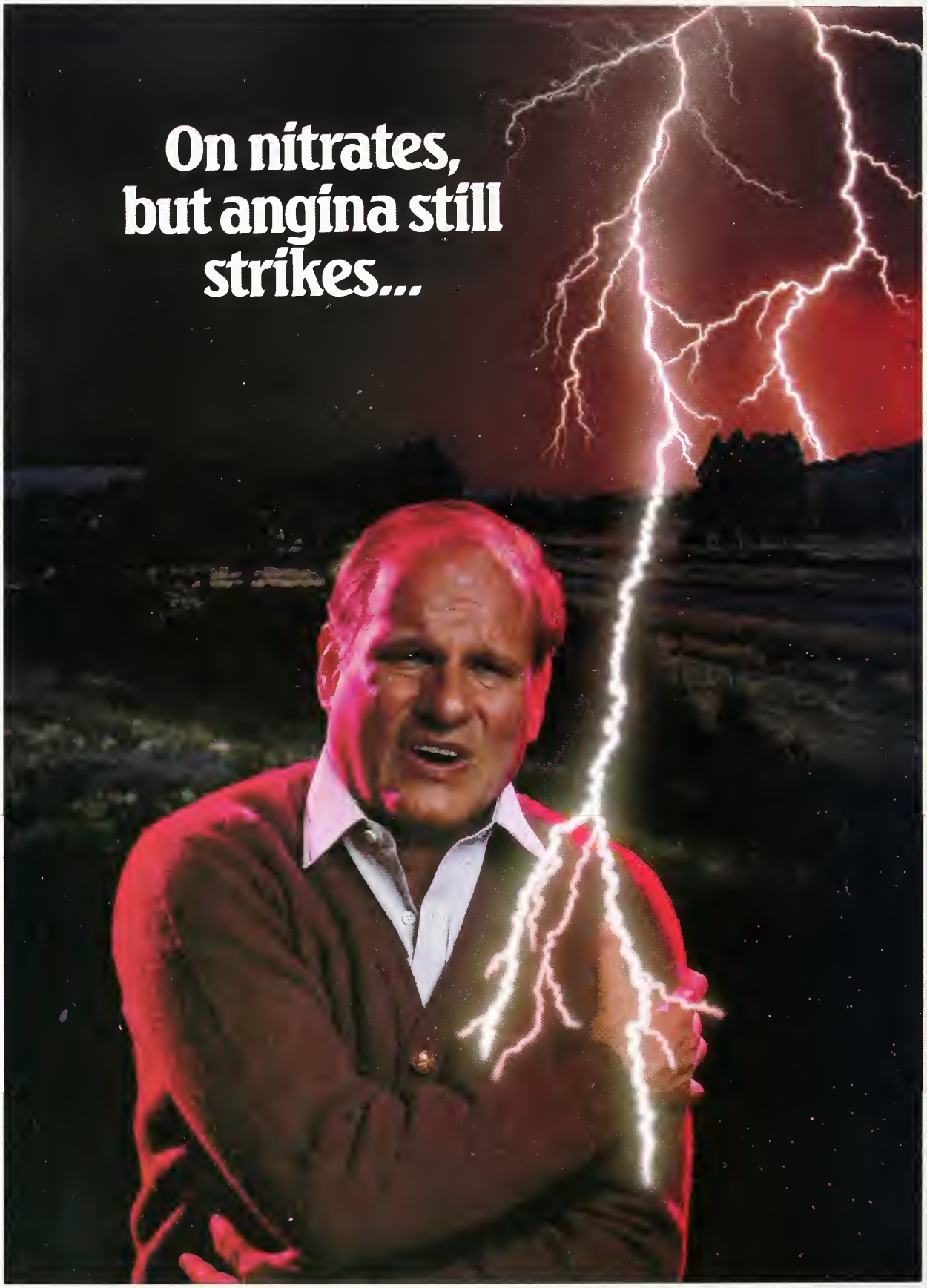
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but angina still
strikes...

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(verapamil HCl/Knoll)

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Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EKG

(Continued from page 200)

Answers: 1. B, E 2. B, D

The 12 lead ECG shows sinus rhythm with 2:1 AV block. The atrial rate is 72 beats per minute and the ventricular rate is 36 beats per minute. The PR interval of the conducted P wave is 0.20 seconds and the QRS duration is 0.12 seconds. The QRS is upright in the precordial leads with broad S waves in leads I, II, V_4 to V_6. This QRS pattern is complete right bundle branch block. Three years earlier the patient's ECG had shown complete left bundle branch block and normal AV conduction.

This alternating bundle branch pattern is compatible with disease in the ventricular conducting system. AV conduction includes conduction through the AV node (AH interval) and the His-Purkinje system (HV interval). The clinical ECG cannot differentiate block in these two areas. However, in the presence of bundle branch block, it can be presumed that the 2:1 AV block represents His-Purkinje system block (H-V interval). Although electrophysiology testing could define the area of AV block in this patient, it is not clinically necessary.

The patient was admitted to the telemetry unit for ECG monitoring. Most of his ECG rhythm strips showed 2:1 AV block, but a rare 3:2 AV conduction pattern was recorded. There was no change in the PR interval of the second conducted beat. This was second degree AV block type II (Mobitz) and was also compatible with ventricular conduction system disease. There was no complete left bundle branch block seen on this admission.

A symptomatic patient with a bradycardia can be helped with a permanent pacemaker. Even our mildly symptomatic patient thought he had more energy after pacemaker implantation. Despite his long-standing diabetes and the fact that coronary artery disease is a common cause of bilateral bundle branch disease, there was no history to suggest coronary artery disease. Therefore, there was no indication for cardiac catheterization or coronary angiography.

For more information on conduction system disease, see INTRAVENTRICULAR CONDUCTION DISTURBANCES by Paolo Alboni, Martinus Nijhoff Publishers, 1981. ◀

OBITUARIES

***Conn, Julius,** Wilmette, died March 4, 1986 at the age of 53. Dr. Conn was a 1957 graduate of the University of Virginia School of Medicine, Charlottesville, Virginia. A vascular surgeon, he had been a contributing editor of the *IMJ* "Surgical Grand Rounds" column since 1983. Dr. Conn was a professor of surgery at Northwestern University Medical School.

***Garsenstein, Myron,** Highland Park, died February 19, 1986 at the age of 53. Dr. Garsenstein was a 1957 graduate of the State University of New York at Buffalo School of Medicine, Buffalo, New York.

***Hausmann, Edwin G.,** Aurora, died February 24, 1986 at the age of 77. Dr. Hausmann was a 1936 graduate of Rush Medical College, Chicago.

***Holden, Lawrence B.,** Peoria, died February 14, 1986 at the age of 67. Dr. Holden was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

****Keller, Samuel L.,** Waukegan, died January 16, 1986 at the age of 93. Dr. Keller was a 1920 graduate of the University of Nebraska College of Medicine, Omaha, Nebraska.

****Koza, John L.,** Delavan, Wisconsin, died February 27, 1986 at the age of 76. Dr. Koza was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

***Lampert, Elmer G.,** Aurora, died February 25, 1986 at the age of 72. Dr. Lampert was a 1940 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Morrison, Frank A.,** Alton, died February 20, 1986 at the age of 74. Dr. Morrison was a 1936 graduate of the University of Nebraska College of Medicine, Omaha, Nebraska.

***Robbins, Joseph H.,** Chicago, died February 13, 1986 at the age of 61. Dr. Robbins was a 1953 graduate of the University of Illinois College of Medicine, Chicago.

***Wicks, William R.,** Godfrey, died February 21, 1986 at the age of 67. Dr. Wicks was a 1943 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

****Willstead, Otterbein D.,** Brooksville, Florida (formerly of Chatsworth), died January 4, 1986 at the age of 94. Dr. Willstead was a 1916 graduate of the Chicago College of Medicine and Surgery.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Don't Tread On Their Tows

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

There are times when folks in Mt. Hawley get upset. On rare occasions, a few have been known to get mad. Never can I recall any getting as hot as did Moe and Bun when they got the notice of the fee that they would be obliged to pay for operating their hooker under a new law in the great state of Illinois!!

Possibly I should back up a bit and explain that Moe and Bun own a tow truck (known in CB parlance as a 'hooker'). The "BIG TOE," their affectionate name for this awesome vehicle, is as much a part of their being as their true pedal appendages, and they were past the boiling point because of this new regulation and what that silliness was going to cost them!

I'm not altogether certain of the actual facts—cold, clear, objective words of fact are difficult to get from agitated persons who are gesturing and illustrating their points with a tire iron in one hand. Seems, though, that because of some slippery towing operators in Chicago, the state had decided to crack down on all operators in the state and hedge the issue by charging every one a larger license fee.

"Ain't fair—ain't right—ain't goin to pay it" became the war cry of Moe. Bun being older and a little more realistic, finally cooled off enough to say, "True, it ain't fair, and it ain't right, but we're going to have to pay to stay in business."

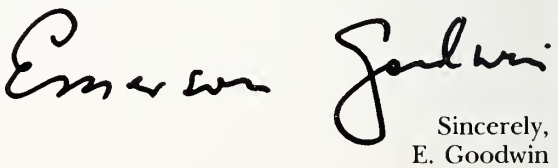
All of this illustrates a common public mechanism at problem solving. When a problem surfaces, it is easier to spread the responsibility and the cost through all like businesses and/or people than it is to point the finger or the sword at the one that done it. Every one pays a little—now becoming a lot—and the total cost is covered, or the bad activity is discouraged. . . . Does that sound like a small town boy's definition of insurance??

However there is another side to this. May even be part of a solution! What Bun and Moe have not yet tumbled to is that a lot of tow truck operators must be every bit as mad. If they were to get together, there'd be enough tire irons in motion to cause folks in the state to wonder about the wisdom of their previous action—they might even start looking for other answers.

Strikes me that you medical folks have already figured out both points. You've known all along that it's your responsibility to identify and to do something about those docs that aren't up to snuff. As I understand it, that's what your peer review has been about these many years. Now you are trying to get the licensing folks to listen to you and to act appropriately—and I wish you well.

Secondly, although you were first, others are having liability problems as well. You all were more alert, noted this first and got to doing something about it in Springfield. Now the problem in getting insurance is everywhere—even here in Mt. Hawley, where the TEN PIN Bowling Alley Grill and Cocktail Lounge had to pay three times last year's premiums. Would have had to close up, but survived for another year by raising lines and beer twenty-five cents each.

I know that all of your folks have had to raise their fees to meet those increased malpractice premiums. Now that a lot of other folks have had to do the same thing to cover their costs, and to keep their protection, it seems to me that the crisis is past crisis proportions. There must be a lot of folks out there with tire irons, bowling pins and anger. Your challenge will be to get them on line with you. Folks are much more likely to become motivated when it's their toes—or tows—that have been stepped on. Hope you can get that motivation captured and going in your direction.



Sincerely,
E. Goodwin

Please post this announcement on your hospital bulletin board.

BUSINESS IN MEDICINE

Political-Economic, Medical-Legal and Negotiating Seminars

May 16-19,'86 - Chicago Nov. 6-9,'86 - San Diego

For:* • *Physicians* • *Residents* • *Managers

Chicago Keynote: William Rial, M.D., Past President (1982-83), A.M.A.

OBJECTIVES:
- Understand current politcal effects on medical practice
- Improve quality assurance and risk management
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METHODS:
- Pre-seminar basic background papers
- Seminar with lectures, panels, and workshops
- Post-seminar published proceedings and tapes

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*"Excellent weekend meeting ..."**

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FRIDAY, MAY 16

Registration Reception

SATURDAY, MAY 17

Government in Medicine 8:30 - 12:00
HEALTH CARE IN THE 1990'S
FEE FREEZE AND ASSIGNMENT
HOSPITAL AND PHYSICIAN DRG'S
GRAMM-RUDMANN EFFECTS

Business in Medicine 1:00 - 4:30
UNDERSTANDING THE BLUES
IPA's, PPO's and HMO's
HOSPITAL-MEDICINE INC.'s
JOINT VENTURES

Concurrent Workshops 4:45 - 6:00
LEGISLATIVE UPDATE
REGULATORY UPDATE
EVOLVING PRACTICE PATTERNS

Negotiating Technique 7:30 - 9:00

SUNDAY, MAY 18

Medical-Legal Issues 8:30 - 12:00
MALPRACTICE
STAFF ORGANIZATION
SOCIETIES AND UNIONS
TRUSTS AND ANTITRUST

Afternoon Workshops 1:00 - 5:00
COST-EFFECTIVE PREVENTION
PHYSICIAN CONTRACTS
TORT REFORM
PEER REVIEW FUTURE

Negotiating Critique 7:30 - 9:00

MONDAY, MAY 19

Concurrent Workshops 8:30 - 12:00
PROFESSIONAL LIABILITY
NEGOTIATING PARTICIPATION

Concurrent Workshops 1:00 - 4:30
IPA/HMO ORGANIZING/MANAGING
NEGOTIATING WITH HOSPITALS

*"The faculty was well versed...material presented was mostly new"**

Peter Bouxsein, J.D.
Counsel, Subcommittee on Health and Environment, U.S. House of Representatives

Alfred Clementi, M.D.
Chairman of Board, Ill. State Medical Society
Director, Ill. State Medical Insurance Services

Jerry Clousson, J.D., L.L.M.
President, Physician Support Services, Inc.
Former Director, A.M.A. Dept. of Negotiation

George Collentine, M.D.
Medical Director, Compucare of Wisconsin
Assoc. Clinical Professor of Surgery, M.C.O.W.

Richard J. Daley, J.D.
Partner, Pierce Daley Baffes & O'Sullivan

Jim Dechene, J.D., Ph.D.
Associate, Sidley & Austin, Chicago

Thomas Dehn, M.D.
Pres., American Medical Peer Review Assoc.

Barbara Gagle
Regional Administrator, Chicago
Health Care Financing Administration

Robert A. Go
Partner, Touche Ross & Co., Detroit
National Health Care Industry Director

Richard King, J.D.
Assoc. Exec. Director and General Counsel
Indiana State Medical Association

Edward Lichter, M.D.
Chairman, Prev. Medicine and Community Health, U. of Illinois College of Med. at Chicago

Philip G. Lindner
Partner, Arthur Anderson & Co., Chicago

Paul S. Mannweiler, J.D.
Majority Whip, Indiana House of Representatives
Author, 1985 Malpractic Ammendments

William Rial, M.D.
Exec. Director, Health Benefits Management
Blue Cross and Blue Shield Association
Past President (1982-83), A.M.A

Terry Tottenham, M.D.
Partner, Fulbright & Jaworski, Houston
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Walter Wood, M.D.
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Loyola University of Chicago

Quentin Young, M.D.
Pres., Health and Med. Policy Research Group
Clin. Prof., P. Med. & Comm. Health, U. of Ill.

William B. Zeiler, M.D.
Pres., Clinical Pathology Facility, Pittsburgh
Vice Pres., College of American Pathologists

*"The conference facility was comfortable"**

LOCATION: The Arlington Park Hilton, Euclid Ave. and Rohlwing Rd., Arlington Heights, Illinois, offers group discount rates, free guest parking and complimentary transportation from the American Airlines baggage claim area at O'Hare.

C.M.E. CREDIT: Loyola University of Chicago designates this program for 23 hours in Category I of the A.M.A.-Physician's Recognition Award.

*"...an excellent buy for the money."**

FEES: Registration $90 or $60/day (see below) includes background papers and lecture notes but not lodging, meals, proceedings or tapes.

INFORMATION: (812) 299-5658

"...every practitioner should attend"*

* *Comments by previous participants*

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Fees: ☐ **Physician** ☐ **Resident** ☐ **Manager** ☐ **Fellow**

☐ May 16-18: **$180** **$120** _____

☐ May 19 **$ 90** **$ 60** _____

☐ Check to **Business in Medicine** _____

Arlington Park Hilton Reservation:

☐ **Single ($57.00)** ☐ **Double ($77.00)**

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☐ Male ☐ Female ☐ Non-Smoker

arriving May_____, '86; **departing** May_____, '86

☐ No room needed (add $8/day to fees)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MAY

Allergy

Resident-Fellow Abstact Presentation
For: Allergists. May 19, 6:00 (cocktails), 7:00 (dinner), 8:00 p.m. (meeting), Holiday City Centre, Chicago, IL. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1.5 hours. **Contact:** Dianne K. Kubis. **Phone:** (312) 255-1024.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, May 16-18, Chicago, IL. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Mary Ann Dillon. **Phone:** (312) 962-1056.

Pediatrics/Neurology

Medical Seminar-at-Sea (Fjords)
For: Physicians. Symposium, May 17-28, British Isles/Ireland/Norway. **Sponsor:** Southern Illinois University School of Medicine, CME, P.O. Box 3926, Springfield, IL 62708. **Fee:** $500. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine

17th Family Medicine Review
For: Family Physicians. Course, May 18-23, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $425 ($450 after 5/2). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP Elective: 50 hours. **Contact:** Rosemary Fisher. **Phone:** (606) 233-5264.

2nd Annual Conference on Controversies in Family Medicine: Who Pays When the Safety Net Fails?
For: Physicians and other health professionals. Conference, May 1-2, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Department of Family Medicine, University of Wisconsin, 465B WARF Bldg., 620 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA Category 2-D and University of Wisconsin CEU's: 13 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Vascular and Pulmonary Diseases: Diagnosis and Management
For: Primary care physicians. Lecture and Workshops, May 16-17, Hyatt Regency-Chicago, IL. **Sponsor:** University of Colorado, Medical Education Resources, 5808 South Rapp Street, Suite 202, Littleton, CO 80120. **Fee:** $295. **Reg. Limit:** 50. **Credit:** Category 1: 11 hours; AAFP Prescribed: 11 hours. **Contact:** Deborah Wilderson. **Phone:** (800) 421-3756.

Sports Medicine/Orthopedics

2nd Annual Sports Medicine Symposium
For: Physicians and other health professionals. Conference, May 16-17, Madison, WI. **Sponsors:** University of Wisconsin-Madison, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Division of Orthopedic Medicine, University of Wisconsin Hospital, Sports Medicine and Fitness Center. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; AAFP credit pending; AOA Category 2-D, and University of Wisconsin CEUs: 11. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, May 11-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $750. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Surgery

Advances in Surgery, 1986
For: General and specializing surgeons. Lecture, May 5-9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $540. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Warren H. Cole Symposium XIII
For: Surgeons. Lecture, May 14-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 19 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons. Lecture, May 31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $145. **Reg. Limit:** 90. **Credit:** Category 1: 7 hours; AAFP Prescribed: 7 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Ophthalmology

Annual Residents-Alumni Day Meeting-University of Illinois Dept. of Ophthalmology
For: All alumni and area ophthalmologists. Lectures and paper presentations, May 15, 8:00 a.m.-5:00 p.m., Eye and Ear Infirmary, Chicago. **Sponsor:** University of Illinois at Chicago, Department of Ophthalmology, 1855 W. Taylor Street, Chicago, IL 60612. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Donald Sanders, M.D., Ph.D. **Phone:** (312) 996-6989.

Internal Medicine

Iowa Scientific Meeting
For: Iowa Region of American College of Physicians. Symposium, May 9-10, Iowa City, IA. **Sponsors:** American College of Physicians and the Iowa Clinical Society of Internal Medicine. **Fee:** $15 for ACP members and $20 for non-members. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Robert B. Fick, Jr., M.D. **Phone:** (319) 356-2738.

JUNE

OBGYN/Family Medicine

Update in OBGYN
For: OBGyn and family physicians. Course, June 13-14, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, Office of Continuing Education, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP: 10. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

OBGYN/Family Medicine/Urology

Medical Seminar-at-Sea (North Cape Cruise)
For: Interested physicians. June 21-July 3, North Cape. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $500. **Credit:** Category 1: 48 hours. **Contact:** Charles Osborne, Ed.D.. **Phone:** (217) 782-7711.

Chicago Area Schools of Medicine Obstetrics and Gynecology Review
For: OB/Gyn's. Course, June 16-21, Chicago, IL. **Sponsors:** Seven medical schools of Illinois, c/o The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $550. **Reg. Limit:** None. **Credit:** Category 1: 42 hours; ACOG: 42 Cognates. **Contact:** Mary Ann Dillon. **Phone:** (312) 926-1056.

Otolaryngology

Chicago Temporal Bone Dissection Course
For: Otolaryngologists/residents. Course, June 2-6, Hinsdale, IL. **Sponsors:** Department of Otolaryngology for Northwestern, Loyola and Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521. **Fee:** $900 (physicians), $600 (residents). **Reg. Limit:** 8. **Credit:** Category 1: 40 hours. **Contact:** Cheri Jones, M.P.H. **Phone:** (312) 887-2400.

Pathology

DNA Hybridization in Surgical Pathology
For: Pathologists. Lecture, June 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** (CME credit is for members only) Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Department of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Cardiology

Cardiac Rehabilitation
For: Interested health professionals. Workshop, June 16-20, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Cardiology

Cardiac Rehabilitation for Children
For: Interested health professionals. Workshop, June 27-28, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $225. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Fitness/Weight Control

Fitness and Weight Control
For: Interested health professionals. Workshop, June 9-13, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Exercise

Graded Exercise Testing (GXT)
For: Interested health professionals. Workshop, June 23-26, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:**

Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact**: Philip K. Wilson, Ed.D. **Phone**: (608) 785-8686.

Stress Management
Teaching Stress Management and Relaxation Skills
For: Interested health professionals. Workshop, June 2-6, LaCrosse, WI. **Sponsors**: University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee**: $450. **Reg. Limit**: 40. **Credit**: Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact**: Philip K. Wilson, Ed.D. **Phone**: (608) 785-8686.

Hospital Administration
Marketing Stategies: A Diagnostic and Prescriptive Analysis for Corporate/Employee Services, Commercial, and Public/Private Wellness Programs
For: Hospital administrators, interested health professionals and marketing/advertising professionals. Workshop, June 16-19, LaCrosse, WI. **Sponsors**: University of Wisconsin-LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee**: $450. **Reg. Limit**: 40. **Credit**: Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact**: Philip K. Wilson, Ed.D. **Phone**: (608) 785-8686.

Pediatrics
Annual Update in Pediatics
For: Pediatricians, Family practitioners. Workshop, June 6-7, St. Louis, MO. **Sponsors**: St. Louis University School of Medicine, 1402 South Grand Blvd., St. Louis, MO 63104 and Cardinal Glennon Children's Hospital. **Fee**: $150. **Reg. Limit**: None. **Credit**: Category 1: 10 hours; AAFP Prescribed: 10 hours. **Contact**: Anita Herbst. **Phone**: (314) 577-8167.

Trauma
Advanced Cardiac Life Support Provider Course
For: Physicians and allied health professionals. Workshop, June 28-30, St. Louis, MO. **Sponsors**: St. Louis University School of Medicine, 1402 South Grand Blvd., St. Louis, MO 63104 and St. Louis Chapter of the American Heart Association. **Fee**: $150. **Reg. Limit**: 45. **Credit**: Category 1: 20 hours. **Contact**: Anita Herbst. **Phone**: (314) 577-8167.

JULY

Cardiology
Cardiac Rehabilitation
For: Interested health professionals. Workshop, July 21-25, LaCrosse, WI. **Sponsors**: University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee**: $450. **Reg. Limit**: 40. **Credit**: Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact**: Philip K. Wilson, Ed.D. **Phone**: (608) 785-8686.

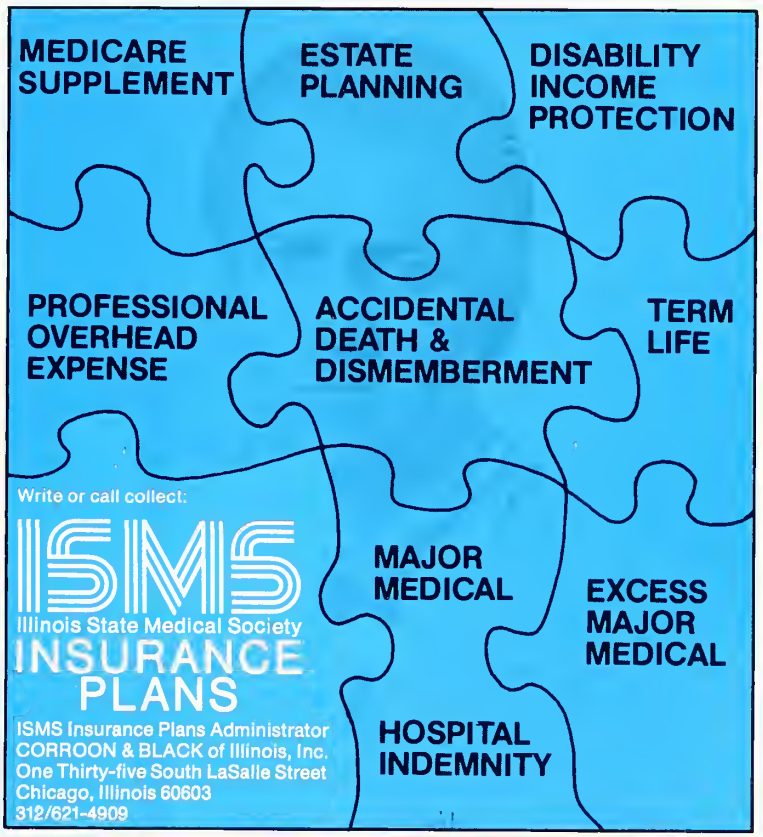
Stress Management
Teaching Stress Management and Relaxation Skills
For: Interested health professionals. Workshop, July 14-18, LaCrosse, WI. **Sponsors**: University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee**: $450. **Reg. Limit**: 40. **Credit**: Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact**: Philip K. Wilson, Ed.D. **Phone**: (608) 785-8686.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education (DRE)

Disciplinary Orders

- *Philip Coleman* (lic. # 036-043834)
  Effective January 28, 1986, the medical license of Dr. Coleman was placed on probation, subject to certain conditions.
- *Edward G. Fortier* (lic. # 036-029037 & 003-036-029037)
  Effective January 29, 1986, Dr. Fortier's medical and controlled substance licenses were summarily suspended pending a later hearing.
- *George M. Keranen* (lic. # 036-35318)
  Effective February 15, 1986, Dr. Keranen's medical license was revoked.
- *John Kitakufe* (lic. # 036-060163 & 003-036-060163)
  Effective January 29, 1986, Dr. Kitakufe's medical and controlled substance licenses were summarily suspended pending a later hearing.
- *Jason D. Smith, D.O.* (lic. # 036-057474 & 003-036-057474)
  On January 29, 1986, the medical and controlled substance licenses of Dr. Smith were summarily suspended pending a later hearing.

(Source: Disciplinary orders received by ISMS)

License Renewal of Registered Nurses

License renewal notices are being sent out to actively licensed Illinois registered nurses whose current licenses expire May 31, 1986. These notices will not be forwarded and it is imperative that DRE have current names and addresses for these nurses.

Please remind all nurses in your practice to submit any name and/or address changes to the Department immediately if they have not already done so. They should inform DRE in writing of their name and address, their *license number* and the appropriate change(s).

If there is a change to be made, a nurse must also include certified documentation of the change, *i.e.*, marriage license or divorce decree. No fee is required for making these changes in the record. This information should be sent to: Licensure Maintenance Unit, Ill. Dept. of Registration & Education, 320 W. Washington St., 3rd Floor, Springfield, IL 62786.

As it takes 3-4 weeks to process each renewal, the renewal forms should be submitted with the $20 fee no later than May 2, 1986 in order to receive a new license by May 31, 1986.

Physicians who desire to accommodate those individuals who do not submit their materials in time to get their renewals by May 31st may adopt a policy to allow them to continue practicing upon proof of completion and payment of the renewal. Cancelled checks, money order receipts or return mail receipts may be accepted as proof of payment.

Included in the renewal notices will be the 1986 RN Survey questionnaire. This information regarding Illinois' RN population is used for nusing and health care planning. This year's legislative proposals regarding nursing make such information important. The survey forms should be returned in the same envelope as the renewal notice.

(Source: Correspondence from DRE Nursing Education Coordinator)

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One of Your Clients Called, Doctor

By Marc A. Pomerantz, M.D./Chicago

The word *client* is creeping into medicine's jargon. There is a determined effort from three fronts to substitute this term for *patient.* In 1925, a social worker was the first to use the word in print to refer to the people he served.[1] As social workers became more independent, they adopted the word into their jargon with real fervor. This may have grown from a desire to emphasize the difference between their services and those of a physician, or to express the idea that they dealt with people on a global level beyond that of physical illnesses.

Nurses now have more independent practices on both an individual and an agency level, and they, too, are beginning to refer to patients as clients. The word has even begun to appear in the nurse's portion of hospital records. Their reasons are probably the same as those of the social workers.

The most recent assault on the physician-patient relationship comes from government agencies. In their concern with cutting costs, they have striven to demean the act of caring for sick people to the status of a purely economic relationship. While the present attack may be limited to semantics, the implications for the future are more serious. This would appear to reduce physicians to the status of any vendor of goods and services. In fact, the term vendor is used on some of the physician forms.

Vendors are actually in a better position than physicians in dealing with the government. A vendor who deals in material goods has fixed costs which are widely known. But physicians deal mostly with intangible services, and are forced to accept whatever price an agency, unilaterally, sets for those services, even when that price barely meets the expenses incurred.

According to the Oxford English Dictionary, the word client derives from the Latin word *cliens,* which meant a plebian who was bound to a patron who, in turn, protected his subject's life and interests in return for certain services. It is used to define the relationship between a business person or professional and a customer. The term implies a primarily financial relationship.[2]

The traditional physician/patient relationship has been recognized as much more than that of buyer and seller. Dorland's Medical Dictionary does not contain the word client but defines a patient as, "a person who is ill or who is undergoing treatment for disease."[3] No mention of financial arrangements is made.

Some physicians have bowed to the pressures of modern life by streamlining and automating their offices. Even within the most sterile of professional settings, acts of compassion occur daily that go far beyond the economic concerns involved.

Like most physicians, I give medical care to some patients who will pay when they can, if at all. The responsibility to do so is a legacy which we accept with the M.D. degree, and it probably predates written history. The Hippocratic injunction to collect a fee before complete recovery has occurred suggests that even the ancient Greeks did not always pay their doctors' bills.

Now is the time to fight against this insidious attempt to demean physicians, before the idea that we are just businessmen in white coats becomes entrenched in the public and governmental mind. We should encourage our local and national societies to argue against the reference to clients by governmental bodies. On a personal level, we should resist the use of this word by other "health care workers," and we should continue to care for the sick with the compassion that has made the title, physician, an honored and respected one. ◀

References

1. Burchfield R.W., Ed.: A Supplement to the Oxford English Dictionary, 1: 544, Clarendon Press, Oxford, England, 1972.
2. Philological Society: The Oxford English Dictionary, II: 497-8, Clarendon Press, Oxford, England, 1978.
3. Dorland's Medical Dictionary: 26th ed., 978, W.B. Saunders Co., 1974.

Marc A. Pomerantz, M.D., is a board certified surgeon affiliated with Rush-Presbyterian-St. Luke's Hospital, Chicago. Dr. Pomerantz is a fellow of the American College of Surgeons and is chairman of the disaster committee at Rush.

Go For the Games!

ISMS Physician Games

The second ISMS Physician Games are scheduled for Friday, August 15 and Saturday, August 16, 1986, at Marriott's Lincolnshire Resort, Lincolnshire, Illinois. Coordinated by the ISMS Sports Medicine Committee, the Physician Games provide a unique opportunity for physicians and their spouses to compete in sporting competitions, attend sports medicine and fitness programs, and socialize with other physician couples in a friendly, recreational atmosphere.

Something for Everyone

Individual and team competitions will be held in golf, tennis, racquetball, handball, swimming, track and volleyball. A special karate clinic will feature demonstrations by physician experts. New events, such as trap shooting and one-on-one basketball, are also being considered. Separate tournaments for men and women have been scheduled.

This year, hospital medical staffs and county medical societies are invited to enter teams for the volleyball tournament and track and swim relay races. Medical students and residents are also invited to participate in their respective categories in team and individual contests.



The Sports Medicine and Fitness Presentations

Three clinical and health presentations are planned for this year's Games:

- On Friday evening, a clinical seminar on ankle injuries will be presented by the ISMS Sports Medicine Committee. A panel will discuss and demonstrate ways to prevent and treat ankle injuries. A hands-on taping session will teach participants the skills needed for immediate and preventive care.
- The featured speaker for our Saturday Women's Health and Fitness Luncheon will be Mona Shangold, M.D., director of sports gynecology, Georgetown University School of Medicine, Washington, D.C. Dr. Shangold's topic will be fitness after age 40.
- The Physician Games awards banquet will have an Olympic theme and feature Eugene Osher, M.D., medical director of the Los Angeles Olympics. Dr. Osher will share his observations and experiences as the physician responsible for the medical care of the world's best athletes during the 1984 Olympics.

For Further Information

For more information about the ISMS Physician Games please call or write: ISMS Physician Games, Illinois State Medical Society, Twenty North Michigan Ave., Suite 700, Chicago, Illinois 60602; 312-782-1654. ◀

Dental Management of Cancer Patients Receiving Chemotherapy

By LaDeane Fattore, D.D.S., Richard A. Larson, M.D. and Reza S. Mostofi, D.M.D./Chicago

Both the number of patients receiving cancer chemotherapy and the intensity of the drug regimens employed have increased in recent years. An increasing number of patients currently require careful evaluation and management of a variety of oral problems. This paper reviews the direct and indirect effects of cancer chemotherapy on dental health and describes alternatives for prophylaxis or treatment of the most common problems.

Patients with cancer may develop problems within the oral cavity as a direct result of malignant disease or secondary to anti-cancer treatment. Patients with leukemia or lymphoma are markedly immunosuppressed, and have an increased risk of oral infection. Patients with carcinoma of the head and neck may have ulcerated lesions in the mouth. Many patients with disseminated cancers experience anorexia and have abnormal nutrition. These factors have an impact on the health of the oral cavity. It is important to recognize that many of these potential complications of cancer may, paradoxically, become worse during the course of treatment.

Destruction of malignant cells by cytotoxic drugs has proved to be an effective treatment for a variety of malignant diseases. The anti-tumor effect of cancer chemotherapeutic agents is based on their ability to retard cell division or to destroy rapidly proliferating cells. Unfortunately, normal cells with a high mitotic index in tissues, such as the oral and gastrointestinal mucosa, bone marrow, hair follicles, and skin, are also prone to these toxic effects. The oral mucosa, with its rapid cell turnover and frequent trauma, is a common site of toxicity.[1] In addition, the endogenous flora of the oral cavity make this site an important potential portal of entry for infectious organisms in the immunosuppressed cancer patient.[2]

A thorough prechemotherapy oral examination is important. This information, along with a consideration for the patient's disease, prognosis and laboratory values, allows for realistic planning for dental management prior to, during, and following cancer chemotherapy. Preventive measures for the eradication and control of oral disease are particularly important in this patient population.[3]

Direct Effects of Chemotherapy

Direct stomatotoxicity or stomatitis results from the cytotoxic action of chemotherapeutic agents on oral mucosal cells. A decrease in the renewal rate of the basal epithelium causes atrophic thinning of the oral mucosa.[4] Clinically, patients experience pain. The oral mucosa becomes erythematous and ulcerated. Direct stomatitis most commonly occurs on the nonkeratinized surfaces of the mouth, such as the buccal and labial mucosa, ventral and lateral surfaces of the tongue, the soft palate and the floor of the mouth. Stomatitis is most often observed within one week following administration of the chemotherapeutic agent.[5] Stomatitis is commonly produced by methotrexate, doxorubicin hydrochloride, 5-fluorouracil, bleomycin, or cytosine arabinoside, and is more common with higher doses. These effects are usually self-limiting, and healing without scarring occurs within 2-3 weeks.[4]

Palliation of moderate stomatitis

may be achieved through the use of equal parts of diphenhydramine elixir and kaolin with pectin used as a mouth rinse. Lidocaine hydrochloride (2% viscous) with 25mg diphenhydramine elixir may also be helpful. For severe stomatitis, a topical anesthetic spray composed of benzocaine, butyl aminobenzoate, tetracaine hydrochloride, benzalkonium chloride and cetyl dimethyl ethyl ammonium bromide may be helpful. Acetaminophen with codeine elixir is also palliative. The elixir is taken 30-60 minutes before meals. It can be swished around the mouth and then swallowed for both local and systemic effects.

Indirect Effects of Chemotherapy

Stomatotoxicity also results as an indirect effect of the suppression of normal bone marrow cells by chemotherapy. Myelosuppression is a common sequela of many forms of cancer chemotherapy. Secondary changes in the oral cavity are usually observed 12-16 days following the administration of the drug; this corresponds with the nadir of the white blood cell count in patients who become neutropenic.[5]

The sites where the effects of neutropenia are most frequently noted are in the areas of the marginal, papillary, and attached gingiva. These are areas where pre-existing chronic infection predisposes the patient to further destruction and infection. Once the initial breakdown of the gingiva is established, ulcerative lesions with surface necrosis may spread to any area of the mucosa. Secondary infection and bleeding are common. However, it is important to remember that when a patient's granulocyte count is significantly reduced ($<100/\mu l$), the cardinal signs of inflammation may be absent or indiscreet.[6]

Hemorrhage is another common sequela of myelosuppression and the resultant thrombocytopenia.[6] Oral bleeding was noted in 57% of cancer patients with platelet counts less than $60,000/\mu l$.[3] Spontaneous gingival bleeding may occur whenever the platelet count is less than 15,000-20,000 cells/μl.[3,7] As with other forms of indirect stomatotoxity, patients with underlying periodontal disease are more likely to develop hemorrhage than are patients with good gingival health.[6]

Oral Infections Associated with Chemotherapy

Both endogenous and exogenous microorganisms are capable of producing oral infections which can become life-threatening in patients with reduced host defenses. Oral infections in patients receiving cancer chemotherapy range from surface colonization of the mucosa to superficial and deep ulceration, cellulitis and necrosis, and perforation of the underlying structures. The most frequent sites of oral infection are the lips and tongue; followed by the buccal mucosa, gingiva, palate, and oropharynx.[8] Exogenous organisms acquired in the hospital are frequently more virulent and more resistant to antibiotics than are the endogenous microflora. Prime sources of the exogenous gram-negative aerobic bacilli are hospital food, water, and bathroom facilities.[9]

There is a greater incidence of oral infection in patients receiving the most myelosuppressive chemotherapy protocols. In a study of 1,000 adult patients treated in hospital for acute or chronic leukemia, the oral infection rate was 32.9%.[10] In a companion study of 906 adult inpatients given less intensive chemotherapy for solid tumors, the oral infection rate was 9.5%.[8] Oral infections were more common in the leukemia patients, partly because antileukemia chemotherapy regimens are designed to be more myelosuppressive than those used to treat various solid tumors.

Fungal Infections

Candida is responsible for half of all oral infections that arise during antileukemia chemotherapy and for almost two-thirds of those that occur in patients given antineoplastic drugs for solid tumors.[8] Corticosteroid therapy increases the risk of *Candida* infection. Prolonged antibacterial therapy with broad spectrum antibiotics also increases the risk of fungal supercolonization. The most frequent sites of oral candidiasis are the dorsum, sides and undersurface of the tongue, buccal, gingival, palatal, pharyngeal mucosa, and the commissures of the lips. Candidal colonization is manifested by elevated, creamy-white strands, beads, or patches that adhere to the underlying mucosa. The longer the duration of the infection, the greater the tendency for colony coalescence so large areas of mucosa may be covered. A complication of oral candidiasis is subsequent esophageal infection from swallowing the organisms; penetration of the mucosa may lead to septicemia.[8]

Superficial candidiasis can be treated with topical preparations of nystatin or clotrimazole. Invasive candidiasis requires treatment with intravenous amphotericin B or oral ketoconazole.

Aspergillosis is the second most common fungal infection in immuno-compromised cancer patients. These organisms are usually acquired by inhalation of airborne spores, which then germinate in the mucous medium of the airways.[11,12] Oral aspergillosis often involves the palate, where lesions present as painful, yellowish ulcers surrounded by a black border. Intravenous amphotericin B is the medication of choice for this infection.

Bacterial Infections

Although many anaerobic bacteria are commonly found in the oral cavity, the great preponderance of bacterial oral infections that develop in cancer patients are caused by aerobic gram-negative bacilli (*Pseudomonas, Klebsiella, Serratia, Enterobacter, Proteus* and *Escherichia*) and gram-positive cocci. Lesions produced by *Pseudomonas* are necrotic and enclosed in a reddened halo. Initially, they have a dry, raised, whitish-yellow center that turns purple to black. Ultimately, the necrotic core sloughs off to disclose a bright red shiny bed of granulation tissue.[2]

The oral mucosal infections generated by the other gram-negative bacilli are clinically inseparable. The typical lesions consist of raised, creamy-to-yellow-white, moist, glistening, spreading, nonpurulent, smooth-edged surfaces seated on painful red superficial mucosal ulcers and erosions. Any part of the oral mucosa may become infected. Broad-spectrum intravenous antibiotics should be administered imme-

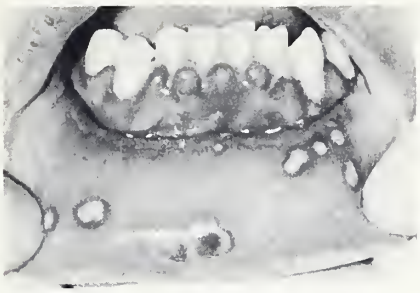


Figure 1
Herpes simplex activated in a patient receiving chemotherapy.

diately upon emergence of the lesions in order to reduce the danger of gram-negative sepsis. This antibiotic coverage should be continued until sensitivity tests of the isolates permit strain-specific treatment.[2]

The frequency of oral staphylococcal and streptococcal infections has declined since the introduction of the semisynthetic penicillinase-resistant antibiotics, but they are still encountered in immunosuppressed patients. Because of the chemotherapy-induced leukopenia, the lesions produced by these organisms have a smaller than usual pyogenic component and often appear as dry, raised, verrucous, yellowish-brown, round plaques.[8]

Viral Infections

During the stress of cancer and its treatment, herpes simplex is frequently activated in the lips of patients harboring this virus. The viral infection manifests itself like a primary herpetic stomatitis. The lesions begin as painful, itching vesicles that rupture within 12 hours and become encrusted with a dried exudate. They often cover large regions of the labial mucosa and extend across the vermillion border. (Figure 1) Amelioration is reported with the topical application of acyclovir ointment 5%.[13,14] Unless secondarily infected, the lip lesions usually regress in 7-10 days.[12]

In summary, the immunosuppressive, myelosuppressive, and cytotoxic effects of cancer chemotherapy diminish all of the natural defenses against microbial infection. As a consequence, there are no benign oral infections in patients lacking protection against microbial attack. Each must be treated vigorously and brought under control as quickly as possible to prevent disseminated infection with potentially fatal consequences.

Dental Support for Patients Receiving Chemotherapy

Cancer patients who present with acute infections prior to chemotherapy require special attention.[15] For example, leukemia patients who are acutely infected at the time of initial diagnosis have a lower survival rate than those who are not acutely infected.[16-18] In a study reported by Peterson *et al.*, 89% of patients who had no evidence of infection at admission achieved complete remission, compared to only 58% of patients who were infected.[15] Among these patients, acute periodontal infection accounted for 42% of all initial infections.[15]

Periodontal disease is an inflammatory response to bacteria that colonize the tooth surfaces adjacent to the gingiva. There is some degree of periodontal disease involvement in 98% of the adult population in the United States. In this condition, bacteria metabolize local nutrients and produce toxins which penetrate the epithelium of the gingival sulcus. The subgingival plaque is composed primarily of gram-negative anaerobic bacteria. The earliest and most obvious clinical symptom of periodontal disease is bleeding, representing an ulcerated epithelial surface.[16]

With chronic periodontal disease, the patient is often unaware of its presence or severity. During periods of myelosuppression, however, acute complications arise. Most patients who develop acute periodontal infections respond well to local irrigation with 10% carbamide peroxide together with broad-spectrum antibiotics.[15] Gentle toothbrushing, flossing, and swabbing with a moist gauze can improve oral hygiene in these patients.

Periodontal treatment for cancer patients is, of course, best undertaken prior to the use of antineoplastic drugs. However, this is often not feasible. Therefore, treatment is postponed until the patient is in remission or until there is an interval during which no chemotherapy is given for several months. Elimination of the periodontal disease process will prevent further acute episodes of infection, and is especially important for patients who will require additional chemotherapy in the future.[16]

In the healthy mouth, the space between the nonkeratinized sulcular epithelium and the cementum does not exceed 3mm in depth when measured with a calibrated periodontal probe. With periodontal disease, the pocket depth can exceed 3mm and become populated with subgingival plaque and gram-negative anaerobic organisms (motile rods, vibrios, and spirochaetes). Removal of these irritating deposits and a thorough smoothing of the roots creates a favorable environment for gingival healing. In more advanced cases of periodontal disease, a gingivectomy may be necessary. With this procedure, the diseased pocket wall which obscures the total surface is removed. In this way the visibility and accessibility that are necessary for complete



Figure 2
Radiographic evidence of periapical pathology.



Figure 3
Draining sinus tract from a tooth with periapical infection.

removal of irritating surface deposits is provided.

Dental Pulpal Disease

Infections which arise from the dental pulp may or may not be symptomatic prior to onset of myelosuppression following chemotherapy. Irreversible pulpal disease should be suspected if a patient describes pain which is spontaneous and throbbing or pain brought on by hot or cold stimuli.[19] Pain upon percussion usually indicates periapical pathology. (Figures 2 & 3) In patients with evidence of periapical disease, endodontic therapy is initiated.

Endodontic therapy is a treatment whereby the contents of a non-vital or diseased root canal are removed and the canal prepared for the filling material. The fill or obliteration of the canal is achieved with an inert material, such as gutta percha. This treatment is the only alternative to extraction in selected teeth.

If the endodontic therapy cannot be completed prior to chemotherapy, it can be completed after the patient has attained remission. Acute infectious complications during subsequent myelosuppression are rarely a problem when the endodontic therapy has at least been initiated.[19]

Dental Extractions

Teeth that are grossly involved with caries and/or periodontal disease should be extracted, unless they are useful for a dental prosthesis. The patient's coagulation status should be checked prior to dental extractions or to deep scaling and oral prophylaxis. A complete blood cell count with platelet count, prothrombin time, and partial thromboplastin time should be measured. In addition, the risk of the contemplated dental procedures should be weighed against the risk to the patient of leaving a focus of infection untreated. The platelet count is a reliable indicator of the relative safety of performing periodontal treatment or extractions. If the count is below $50{,}000/\mu l$,[3] arrangements for platelet transfusion should be made in case hemostasis cannot be achieved with pressure, packing, and suturing,[3,7] Primary closure and alveolectomy at the time of extraction is preferred. If possible, it is advisable to wait at least 10 days between extraction and initiation of chemotherapy, in order to promote primary epithelialization of the wound. This will reduce the port of entry for exogenous organisms.

During chemotherapy, the patient should be instructed to brush his teeth, gums and tongue at least twice daily with a soft-bristled toothbrush to remove food and debris. This brushing will reduce the possibility of gingival or mucosal irritation. The mouth should be rinsed three or four times daily with lukewarm saline solution. Commercial mouthwashes should be avoided, since many of them contain alcohol that dries the oral tissues and irritates ulcerated mucosa.

Flossing must be discontinued when the patient's platelet count drops below $50{,}000/\mu l$.[3,7] If brushing must be discontinued, the patient may cleanse the mouth with a small gauze pad soaked in bicarbonate and saline and wrapped around a tongue blade or finger.

Summary

A thorough oral examination is important in the overall prechemotherapy evaluation of patients with cancer. This information, along with a consideration for the patient's underlying disease history, prognosis, and laboratory values, allows realistic planning for dental management prior to, during, and following cancer chemotherapy. The early establishment of a good working relationship between the patient and all the health care providers, and an understanding of the importance of excellent oral hygiene may reduce chemotherapy-induced morbidity or mortality. ◀

References

1. Sonis, S.T., Sonis, A.L., Lieberman, A.: "Oral Complications In Patients Requiring Treatment for Malignancies Other than of the Head and Neck," *J Am Dent Assoc* 97:468-472, 1978.
2. Dreizen, S., Bodey, G.P., Brown, L.R.: "Opportunistic Gram-Negative Bacillary Infections in Leukemia: Oral Manifestations During Myelosuppression;" *Postgrad Med* 55: 133-139, 1974.
3. Lockhart, P.B.: "Dental Management of Patients Receiving Chemotherapy." In Oral Complications of Cancer Chemotherapy, Peterson, D., Sonis, S. (eds), Martinus Nijhoff Publishers, The Hague, 1983.
4. Guggenheimer, J., Verbin, R.S., Appel, B.N., Schmitz, T.: "Clinicopathologic Effects of Cancer Chemotherapeutic Agents on Human Buccal Mucosa," *Oral Surg* 44:58-63, 1977.
5. Lockhart, P.B., Sonis, S.T.: "Relationship of Oral Complications to Peripheral Blood Leukocyte and Platelet Counts in Patients Receiving Cancer Chemotherapy," *Oral Surg* 48:21-28, 1979.
6. Sonis, S.: "Epidemiology, Frequency, Distribution, Mechanisms and Histopathology." In Oral Complications of Cancer Chemotherapy. Peterson, D., Sonis, S. (eds.), Martinus Nijhoff Publishers, The Hague, 1983.
7. Lynch, M.A., Ship, I.I.: Initial Oral Manifestations of Leukemia," *J Am Dent Assoc* 75:932-940, 1967.
8. Dreizen, S., Brown, L.: "Oral Microbial Changes and Infections During Cancer Chemotherapy." In Oral Complications of Cancer Chemotherapy, Peterson, D., Sonis, S. (eds), Martinus Nijhoff Publishers, The Hague, 1983.
9. Schimpff, S.C.: "Infections in the Compromised Host." In Principles and Practice of Infectious Diseases. Mandell, G.L., Douglass, R.G., Bennett, J.E. (eds.) John Wiley & Sons, New York, pp. 2257-2262, 1979.
10. Dreizen, S., McCredie, K.B., Keating, M.J., Bodey, G.P.: "Chemotherapy-Associated Oral Infection in Adults with Acute Leukemia," *Postgrad Med* 71:133-146, 1982.
11. Taschdjian, C.L., Kozinn, P.J., Toni, E.F.: "Opportunistic Yeast Infections with Special Reference to Candidiasis," *Ann NY Acad Sci* 174:606-622, 1970.
12. Adrian, R.M., Hood, A.F., Skarin, A.T.: "Mucocutaneous Reactions to Antineoplastic Agents," *Cancer J Clin* 30:142-157, 1980.
13. Mitchell, C.D., *et al.*: "Acyclovir Therapy for Mucocutaneous Herpes Simplex Infections in Immunocompromised Patients," *Lancet* 1:1389-1392, 1981.
14. Saral, R., *et al.*"Acyclovir Prophylaxis of Herpes Simplex Virus Infections," *N Engl J Med* 305:63-

67, 1981.
15. Peterson, D.E., Overholser, C.O., Williams, L.T., Newman, K.A., Schimpff, S.C., Wiernik, P.H.: "Acute Periodontal Infection at Admission in Acute Nonlymphocytic Leukemia Patients," *Proc Am Fed Clin Res* 30:422 A, 1982.
16. Peterson, D.: "Bacterial Infections: Periodontal and Dental Disease." In ORAL COMPLICATIONS OF CANCER CHEMOTHERAPY, Peterson, D., Sonis, S. (eds) Martinus Nijhoff Publishers, The Hague, 1983.
17. Kremer, W.B., Vogler, W.R., Chan, T.K.: An Attempt at Synchronization of Marrow Cells in Acute Leukemia," *Cancer* 37:390-403, 1976.
18. Kansal, V., Omura, G.A., Soong, S.J.: "Prognosis in Adult Acute Myelogenous Leukemia Related to Performance Status and Other Factors," *Cancer* 38:329-334, 1976.
19. Peterson, D.E., Overholser, C.D., Williams, L.T.: "Endodontic Therapy in Patients Receiving Myelosuppressive Chemotherapy." *Proc J. Dent Res* 61:276, 1982.

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Use of CAT and Radiation Therapy

Malignant Pericardial Effusion

By Srinivasan Vijayakumar, M.D., D.M.R.T./Cleveland, Ohio

Two cases of malignant pericardial effusion are reported. In each case pericardial effusion was one of the presenting (asymptomatic) manifestations of malignancy. The typical clinical course in malignant pericardial effusion is illustrated. These cases also show the ability of computer assisted tomography to diagnose malignant pericardial effusion during staging work-up, and the effectiveness of external radiation therapy in the prevention or palliation of symptoms and tamponade. Treating when asymptomatic may also prolong the survival. Literature is reviewed in terms of presentation, diagnosis and treatment of malignant pericardial effusion.

Metastatic pericardial disease usually manifests clinically as pericardial effusion (PE). Clinical recognition of malignant pericardial effusion (MPE) is considerably less than its actual occurrence because it is often asymptomatic and can masquerade under other manifestations of malignancy. Lack of physician awareness also contributes to this problem. Two cases are presented which illustrate the natural history of malignant pericardial effusion.[1-5]

Case One

A 58-year-old woman with squamous cell carcinoma of the anal canal was admitted for adjuvant chemotherapy. Chest x-ray showed widening of the mediastinum and a computer assisted tomography scan (CAT) of the thorax (Figure 1) revealed mediastinal adenopathy, pericardial effusion (PE) and pericardial metastasis. Mediastinoscopy and biopsy revealed poorly differentiated adenocarcinoma. Gallium scan was positive in the mediastinum and right and left lower lung fields. She was treated with radiation therapy to the mediastinum, heart (pericardium) and part of the lung with a dose of 3500 rads in 14 fractions. This was followed by chemotherapy. A subsequent CAT of thorax and echocardiogram showed disappearance of PE and pericardial metastasis. Five months later she developed brain metastasis. The patient was treated with whole brain

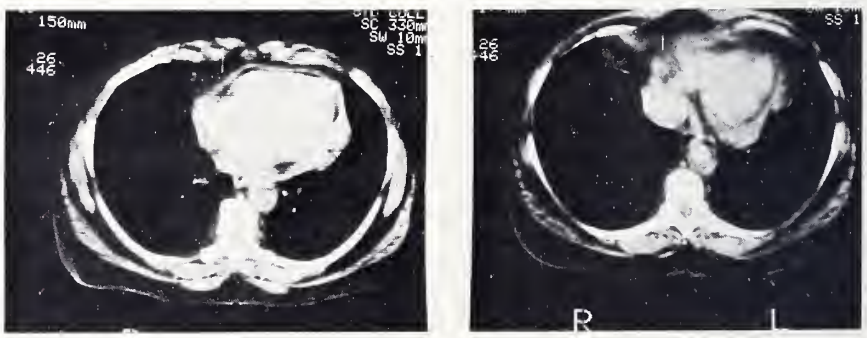


Figure 1
The CAT of the thorax clearly shows the presence of PE, pericardial thickening and probable pericardial metastasis.

radiation. She died the following month.

Comment

This case, in which PE was an asymptomatic presenting feature of malignancy, illustrates the ability of CAT to provide early diagnosis of PE and demonstrates that good palliation and local control are achievable using radiation therapy alone, without pericardiocentesis or pericardial window formation, when there is no tamponade.

Case Two

A 54-year-old woman presented with productive cough and right hilar mass in the chest x-ray. A supraclavicular biopsy revealed large cell carcinoma. Metastatic work-up showed no distant metastasis. As plans were being made for radical radiation therapy, she suddenly developed dyspnea and orthopnea, with distended neck veins. A provisional diagnosis of superior vena caval obstruction (SVC syndrome) was made, and a radionuclide superior vena cavogram (Figure 2) performed. This showed abnormally prolonged stasis of Tc-99m-sulfur colloid in the cardiac blood pool and lungs. The blood pool images demonstrated abnormally large photon deficient areas surrounding the cardiac blood pool. These findings suggested the likelihood of PE and cardiac tamponade and were confirmed by an echocardiogram. The patient underwent needle pericardiocentesis, followed by radiation therapy and systemic chemotherapy. She received 5000 rads in 25 fractions with good response. Retrospectively, radionuclide liver-spleen scan and CAT of thorax (Figure 3) done about 10 days earlier were suggestive of PE. The patient later developed malignant ascites and died two months after first admission.



Figure 2
The radionuclide superior vena cavogram excludes superior vena caval obstruction. Blood pool images showed abnormally prolonged stasis of Tc-99m-S-colloid in the cardiac blood pool with a large photon deficient area surrounding it.

Comment

This case illustrates the poor prognosis of patients with MPE and how easily MPE can be mistaken for other conditions associated with malignancy. It also shows that MPE can be asymptomatic for a considerable length of time before manifesting suddenly and becoming life threatening.

Incidence

Almost every malignancy has been reported as a source of pericardial effusion.[4] The most common primaries, however, are those of the lung and breast and lymphomas, leukemias and melanomas.[4,6,7]

Pathogenesis

The mechanisms of fluid collection include irritative over-production, lymphatic obstruction or both. In experimental models, blocking the lymphatics of the heart without ligating the coronary sinus or anterior coronary veins has not produced PE.[8] Other evidence, however, implicates lymphatic obstruction as the predominant cause. First, there is the invariable involvement of mediastinal nodes in MPE.[9] Second, the majority of cases presenting with PE as the first manifestation of malignancy are from the lung and only one of the 43 cases reported in the literature to date is from the breast primary,[2,5,10-14] in contrast to the equal frequency in advanced malignancies. This can be explained by the proximity of mediastinal lymphatics to lung, serving as the first station, while in breast cancer, the malignant cells must cross the lymphatic "dam" of internal mammary chain or spread hematogenously.

Clinical Picture and Diagnosis

Misdiagnosis of other more common conditions associated with malignancy is responsible for the low[4] antemortem diagnosis of PE. Dyspnea is the most common symptom of MPE (61%-73%),[6,15] with jugular vein distension, palpable liver, ascites and pedal edema. These symptoms, in a patient with a history of chest radiation and cardiotoxic chemotherapy and an enlarged cardiac silhouette in the chest roentgenogram, may suggest congestive heart failure. Similarly, pleural effusion, the most commonly associated sign in MPE (42%-55%)[6,15] may point to pleural or pulmonary metastasis. An enlarged liver may suggest hepatic metastasis. Dyspnea, orthopnea and distended neck veins can be mistaken for SVC syndrome. However, by carefully looking for pulsus paradoxus, widened cardiac dullness and weak and distant heart sounds, diagnosis may not be missed so often. Sometimes, MPE can present with a picture of shock. The key to early diagnosis is a high degree of suspicion.

Roentgenographic and Echocardiographic Findings

Most cases show cardiomegaly,[15] although a normal chest x-ray does not exclude cardiac tamponade,[2,4,16] especially in MPE with the associated pericardial thickening. Fluoroscopy, angiocardiography, pneumoarteriography with carbon dioxide, and simultaneous heart and lung radionuclide scanning can provide additional information and confirm the diagnosis.[17] However, ultrasound is the procedure of choice in the diagnosis of PE with an almost 100% success rate. It also can be performed at the bedside of a very sick patient, and offers safety, simplicity, a non-invasive nature and lower cost.[4,15,18,19] Quantity of PE, pericardial tumor masses, pericardial thickening[17] and the tamponade[4] can also be diagnosed ultrasonographically. CAT also detects PE well, but is not a procedure of choice in an emergency. With the increased use of CAT as a staging procedure for malignancies, it can

serve as an early warning[13] (as seen in our patients.)

ECG

Low voltage complexes are the most common electrocardiographic findings in MPE, although conduction defects, tachy/brady dysrrhythmias, elevation of ST segment, T-wave changes and electrical alternans are all encountered.[4,7,11,15] Total electrical alternans in a cancer patient[4,7,15,20] is strong evidence of cardiac tamponade.

Cytology

The fluid from PE should always be sent for cytologic examination[4,15,18,21] to confirm the diagnosis of MPE, and to assist classification of the histologic type.[21] Although cytology is positive in the majority of cases, a negative cytology does not rule out malignant etiology. About 42% of PE cases among cancer patients in one study were idiopathic or radiation related.[15] A negative cytology makes it mandatory to exclude these causes, since the management differs completely and the prognosis is better than in MPE.

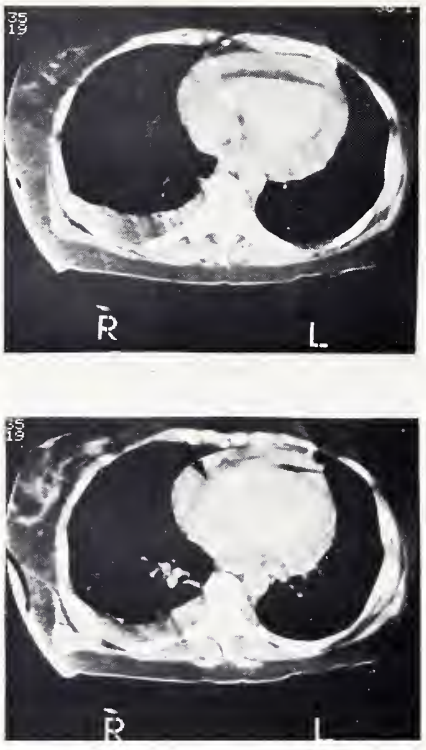


Figure 3
This CAT of the thorax, as in Figure 1, reveals the PE.

Treatment

The survival statistics of patients with MPE are depressing. Mean survival from the time of diagnosis ranges from two to four months in most series.[2,6,7,11,22] However, significant palliation can be achieved in a great majority of these patients, and long-term survivals are encountered.[6,7,11,23-25] The factors determining survival are: (1) the natural history and the behavior of the primary (most long-term survivors' primaries are from breast, ovary or lymph nodes); (2) intrathoracic versus disseminated nature of the disease and (3) the sensitivity of the tumor to radiation or chemotherapy.[22]

The prime concern in a patient with cardiac tamponade is to decrease the intrapericardial pressure. This leads to the pathophysiologic consequences of increased ventricular diastolic pressure, decreased ventricular filling, reduced stroke volume and their resultant manifestations.[4,16] Intrapericardial pressure falls more sharply on removal of the fluid than its increase during accumulation.[4] Rapid relief can occur by the removal of even small quantities of fluid.[4] This is amply seen by the immediate disappearance of electrical alternans.[20]

The literature is divided on the approach to achieving decompression by the removal of the fluid. Some studies favor needle pericardiocentesis[16,18,25] while some support the creation of a pericardial window.[1,17,22,25,26] The former, while effective, carries the complications of ventricular tear, laceration of coronary artery, hydropneumothorax, worsening of tamponade, reaccumulation of fluid, and ventricular fibrillation and other dysrrhythmias.[4,16,18] These can occur in the best of circumstance despite ECG monitoring.[26] Also, the effusions which are small are less likely to be tapped.[18]

Among the surgical procedures for the creation of the pericardial window, the subxiphoid approach, first described by Larrey in 1819,[1,26] appears to be superior to others. It offers simplicity, ability to be performed under local anesthesia, dependent drainage, creation of a wider window,[22,25,26] lower rate of reaccumulation, and complication, and ability to obtain a biopsy specimen, and to proceed to mediastinoscopy if required.[26]

Once the crisis is resolved, the underlying malignancy should be treated and efforts initiated to prevent reaccumulation of PE. Local treatment with external radiation therapy gives gratifying palliation, as illustrated in our patients.[3,6,7,17,24] The radiation dose depends upon the type of tumor and its extent: 20-30Gy are sufficient to achieve palliation in MPE due to leukemia and non-localized lymphoma; 35-40 Gy are required for localized lymphoma and metastatic squamous and adenocarcinoma. However, if the tumor is confined to thorax, and PE is one of the early manifestations, a higher dose is justified. For instance, in lung cancer with no metastasis, 50Gy in 25 fractions, with a higher dose to the gross disease, is recommended. If adjuvant chemotherapy with a cardiotoxic drug is planned, the dose to the heart should preferably be no more than 4000 rads. No decompression is required in the absence of symptoms. Since MPE is usually a manifestation of advanced malignancy, appropriate systemic chemotherapy and/or hormonal therapy should be initiated.

Intrapericardial instillation of various chemotherapeutic drugs and radioactive materials has been described.[3,4,7,17,27] Suffice to say that, at the present time, no definite conclusions can be drawn regarding the additional benefits of intrapericardial instillation therapy.

Summary

Two cases reported here illustrate the ability of CAT to diagnose MPE before it becomes symptomatic. Since MPE carries a better prognosis if treated before the onset of tamponade,[4] PE and/or pericardial metastasis should be suspected during the cancer staging work-up with CAT of the thorax. Pericardiocentesis or pericardial window formation are not necessary at this asymp-

tomatic stage. However, this finding should be considered as an emergency, since tamponade can and will develop shortly. External radiation therapy should be quickly initiated. Our cases illustrate its role.

The additional benefits of CAT of the thorax in MPE include: (1) its complementary nature if echocardiographic findings are inconclusive;[28] (2) its ability to diagnose constrictive pericarditis to help differentiate MPE from radiation induced PE and (3) its ability to provide clues to the malignant etiology in a patient presenting with PE.[29]

References

A complete list of references to "Malignant Pericardial Effusion," may be obtained by writing the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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Phenobarbital Hypersensitivity Reaction

By Renate D. Savich, M.D. and Howard S. Traisman, M.D./San Francisco and Evanston

Adverse reactions to commonly prescribed anticonvulsants, particularly phenytoin, are well documented. This case report is an example of hypersensitivity reaction to phenobarbital, resulting in fever, skin rash, eosinophilia, lymphadenopathy and severe hepatic damage. It is important to recognize this syndrome in patients who are receiving phenobarbital, as hypersensitivity reaction may, in rare instances, result in severe illness or death.

The patient, a seven-year-old Thai female, had been in good health until she fell on the playground, hitting the right side of her head. She did not lose consciousness, but had questionable shaking of her arms and legs. An EEG had revealed a left temperoparietal discharge. Phenobarbital therapy, 60mg b.i.d., had been instituted with no occurrence of "seizure" activity.

Approximately one month later, the patient developed a sore throat, fever to 39°C and a red macular rash which began on the face and spread to the trunk and extremities, excepting the palms and soles. A throat culture was positive for Hemophilus influenzae and she was treated with penicillin for two days and then changed to ampicillin 250mg every four hours. She defervesced for two days and then began spiking fevers every four to six hours.

The patient had no vomiting or diarrhea, joint pain or swelling, or respiratory complaints. She was seen at another hospital for the persistent rash and fever, and admitted. At that time the phenobarbital level was 25.9mcgm/ml.

At this time, phenobarbital and ampicillin were discontinued. However, the next day the mother witnessed arm extension above the head which was interpreted as a seizure. Therapy of ampicillin and carbamazapine, 100mg b.i.d., was instituted, and transfer to our institution was arranged.

On admission, the patient weighed 23kg, measured 119cm, and had normal vital signs. Upon examination she exhibited a diffuse, pruritic, erythematous, fine, maculopapular rash on the entire body, with fine desquamation on the face. Sclerae were non-icteric and the tonsils were not enlarged. There were several large, firm, posterior cervical lymph nodes palpable bilaterally. The abdominal exam was significant for a liver palpable two centimeters below the right costal margin and a palpable spleen tip. Neurological exam was found to be normal.

Initial laboratory results revealed the following: Hgb 11.7gm%, WBC 13,400/mm^3 with polys 17%, bands 32%, eosinophils 12%, lymphs 39%; ESR 10mm/hr, phenobarbital level 9.1 mcgm/ml. The urinalysis was significant for a specific gravity of 1.032 and two plus proteinuria; the microscopic exam was normal.

Phenobarbital was restarted because of the seizure activity; carbamazapine and all antibiotics were stopped. Shortly thereafter, in cooperation with the dermatology and gastroenterology services, the presentation was determined to indicate a phenobarbital drug hypersensitivity reaction and the phenobarbital was discontinued. For two weeks, the patient continued to spike temperatures as high as 40.6° C. The skin rash persisted in desquamating and was treated with Burow's soaks and topical emollients.

The patient maintained a severe leukocytosis for several weeks, up to 41,500/mm^3 with an eosinophilia as high as 19%. The platelet count remained normal. The ESR peaked at 30mm/hr, but then remained below 20mm/hr.

The liver enzyme abnormalities were of greatest concern. The SGOT was initially 251 IU/L and

went as high as 2,775 IU/L. The SGPT on admission was 125 IU/L with a maximum level of 1,830 IU/L. The patient also became markedly jaundiced, with a total bilirubin of 13.8 mg/dl and direct bilirubin of 10.0 mg/dl. She had a low serum protein and albumin of 5.2gm/dl and 2.5gm/dl, respectively. The ammonia level went as high as 78 μg/dl. Not unexpectedly, coagulation abnormalities also developed with a prothrombin time of 20.7 sec (control 13.2 sec), partial thromboplastin time of 46.7 sec (control 32.5 sec), fibrinogen 68 mg/dl (control 265 mg/dl) and fibrin split products greater than 40. The patient received Vitamin K, fresh frozen plasma, and cryoprecipitate, to correct the coagulation abnormalities. Transitory glucose and protein also appeared in the urine. Blood glucose was normal at that time, BUN was 8 mg/dl and creatinine was 0.7 mg/dl. Other normal laboratory studies included blood, urine and stool cultures, stool parasites and ova, bone marrow aspirate, Monospot, hepatitis BSAg, ANA, rheumatoid factor, anti-smooth muscle antibody, febrile agglutinins, and ceruloplasmin. Complement studies were obtained and revealed the following: THC_{50}, 38% (normal range 24-37%), C_3, 123mg/dl (88-155 mg/dl) and C_4, 33.1mg/dl (12-32 mg/dl). The immunoglobulin levels were normal; IgG 965mg/dl (normal range 633-1280mg/dl), IgA 38.3mg/dl (33-202mg/dl) and IgM 75.8mg/dl (48-207mg/dl). Serum IgE levels were not quantified. EBV IgG titer on admission was 1:80, and three weeks later was 1:320. This was of uncertain significance, however, since the EBV IgM titer remained less than 1:16. Other studies included a normal EEG, a liver-spleen scan which showed hepatosplenomegaly and evidence of hepatocellular dysfunction, an abdominal ultrasound which revealed an enlarged liver and ascites, and a gallium scan which showed uptake in the salivary glands. A liver biopsy showed mild chronic active hepatitis and moderate distortion of the hepatic architecture by fibrous bands, suggesting early cirrhosis. Acute and chronic inflammatory cells were present and extended into the hepatic parenchyma. The hepatocytes showed extensive ballooning degeneration. Focal necrosis and occasional eosinophilia were noted within the fibrous tissue and hepatic parenchyma. (Figure 1)

Despite a continued increase in the liver size and jaundice, as well as abnormal liver enzyme studies, the patient became afebrile. Symptoms and laboratory studies eventually returned to normal. On discharge, the patient was still jaundiced with no evidence of skin rash. The liver was still palpable 2cm below the right costal margin. Laboratory studies at this time were WBC 9,100/mm^3 with polys-42%, bands-3%, eosinophils-16%; SGOT 271 IU/L, SGPT 375 IU/L, bilirubin 10.5/7.1mg/dl; PT 13.4 sec, PTT 40.5 sec, fibrinogen 325mg/dl, FSP less than 40. At discharge, Vitamin K was her only medication.

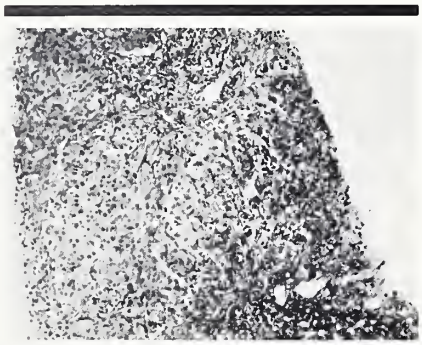


Figure 1.
Distortion of hepatic architecture by fibrous bands with acute and chronic inflammatory cells extending into hepatic parenchyma. The hepatocytes also show ballooning degeneration.

The patient continued an uneventful recovery. Dermatitis and abnormal liver enzyme tests improved. When last examined she weighed 23.5kg (25%) and measured 121.3cm (25%). Vital signs and physical examination were completely normal. CBC, urinalysis and complete blood chemistries, including bilirubin, protein, SGOT, gamma peptidase and alkaline phosphatase, were normal. This child has since been active, healthy and attending school. In view of the above, we elected to defer another liver biopsy unless signs or symptoms of liver disease become evident.

Discussion

There are numerous case reports of phenytoin hypersensitivity reactions in the literature[1-3] involving fever, exfoliative rash, eosinophilia, lymphadenopathy,[4,5] abnormal liver function tests[6] and occasionally hepatic[7,8] and renal[9-12] failure leading to a fatal outcome. However, it is not as well recognized that phenobarbital can cause a similar and equally serious hypersensitivity reaction.[13,14] As with phenytoin, the reaction occurs days to weeks after the onset of drug therapy. Early diagnosis is required to institute prompt withdrawal of the drug.

Our patient exhibited a diffuse, exfoliative, erythematous, maculopapular rash, which eventually resolved. In some cases this rash has been severe enough to involve major bleeding, fluid loss, and electrolyte abnormalities, as with toxic epidermal necrolysis,[15] and may contribute to a fatal outcome. Other rashes in this hypersensitivity reaction may be characteristic of erythema multiforme and Stevens-Johnson syndrome.[1]

In addition to a fever, eosinophilia, and lymphadenopathy, other presenting signs and symptoms of phenobarbital hypersensitivity reactions include leukocytosis,[16] pharyngitis, malaise, splenomegaly, myalgia and arthritis.[17] Of specific interest are the hepatitis[1,2,7,8,10] and nephritis[9-12] which may occur. In our patient, the hepatic abnormality, documented by liver biopsy, continued long after withdrawal of the drug, but eventually resolved. The hepatic damage occasionally may be so severe as to lead to eventual cirrhosis and death several years later,[18] as well as the more immediate possibility of death from overwhelming hepatic failure. Our patient also exhibited transient renal involvement with proteinuria and glucosuria. In some patients, this feature may have more serious sequelae and involve total renal failure.[10-11]

Recent evidence indicates that phenobarbital and phenytoin hypersensitivity reactions are on the basis of an immunological disorder. Several of the studies have suggest-

ed a cell-mediated type of reaction[1,2,9,19] while other reports have indicated an immune complex-mediated type of hypersensitivity.[9,20,21] In view of the marked eosinophilia, pruritis and elevated serum IgE levels seen in several patients, the possibility of an IgE-mediated type of hypersensitivity response must also be considered. Phenytoin has also been associated with low serum IgA levels.[22,23] In our patient the levels were in the low normal range.

After prompt diagnosis and withdrawal of the drug, treatment of the phenobarbital hypersensitivity reaction is mainly supportive.[1] Fluid status and nutrition must be carefully evaluated and controlled. Topical treatment for the exfoliative rash is required, and strict precautions must be taken to guard against infection. Vitamin K, fresh frozen plasma, and cryoprecipitate may be needed for the coagulation abnormalities. In view of the hepatic and bleeding abnormalities, antipyretics must be carefully considered before administration. As with phenytoin hypersensitivity, there is no clear-cut drug therapy for this illness, but steroids may be of some benefit.[1,2,24] This treatment remains controversial, but may be considered in view of the immunological etiology of this illness. If further anticonvulsant therapy is required for a patient with a phenobarbital hypersensitivity reaction, phenytoin is not recommended due to possible cross-reactivity. Instead, treatment with carbamazipine or valproic acid is advised. In those cases with severe hepatic involvement, this may not be feasible, because these drugs may also cause hepatic enzyme changes.

The physician must also be aware that, even after withdrawal of phenobarbital, signs and symptoms of the hypersensitivity reaction may persist for weeks to months, and can result in a fatal outcome.

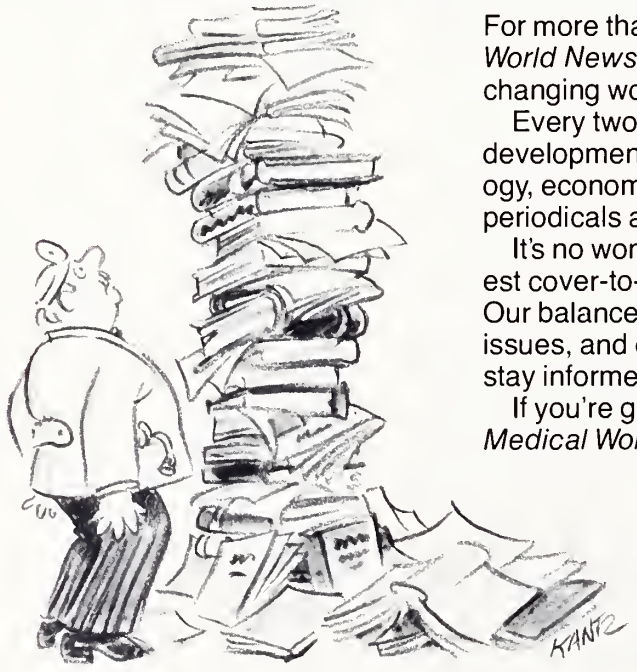
References

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Location Choices of Family Practice Residency Graduates

By John Record, M.A., David Spencer, M.D. and Gabrielle D'Elia, Ph.D./Springfield

During the late 1960s and early 1970s, many medical schools and residency programs were started to help correct geographical imbalance in physician distribution. It was assumed that the location of a physician's birth and education influenced where he or she eventually practiced. Subsequent studies have supported this assumption.[1-9] This paper examines location choices of Southern Illinois University School of Medicine Family Practice Residency Program graduates and identifies influences on those practice location decisions.

Southern Illinois University School of Medicine was established in 1969 as a result of recommendations made by a legislative commission that surveyed the status of health education in Illinois. The family practice program, initiated in 1972, was one of the first residency programs. Two Springfield Community hospitals, Memorial Medical Center and St. John's Hospital, provided the clinical base for the program. In subsequent years, affiliated family practice residency programs were established in Carbondale, Decatur, Quincy and Belleville. Each program utilizes local community hospitals.

Method

Data for this study was collected as part of the Resident Information System. A questionnaire was administered to all incoming residents asking about the location of medical school and home town. About one month prior to training program completion, each resident was given a questionnaire regarding career plans to identify initial practice community location. The population of home town and initial practice locations was determined using 1980 United States Census Bureau figures.

Of particular note was the use of home town instead of birthplace when possible. For purposes of the questionnaire, home town was defined as the place where the individual spent the majority of time through age 18. We were able to identify home town for 47 of the 84 residents included in this survey. Birthplace was used for the remainder of residents and was taken from the residency application forms.

Frequency distributions were used to show the following demographic characteristics: initial practice location, initial community size, home town location, home town size and medical school location. Further analysis was done by cross-tabulating the independent variables, medical school location and home town, with the dependent variable, initial practice location. The chi-square test determined significance.

Results

Data were obtained for 84 individuals who entered and completed the residency program between July 1972 and June 1984. Sixty percent of the graduates remained in Illinois to establish their initial practice; an additional 19% began practice in one of the five states bordering Illinois. The remaining 21% established their initial practice in another state or foreign country. A large majority (84%) chose initial practice communities with a population under 50,000. Only 5% started practice in cities of over 100,000 people. (Figure 1)

We were also interested in the home town size and location and

Figure 1
Initial Practice Location and Initial Community Size of SIU School of Medicine Family Practice Residency Graduates

Demographic Characteristics	Residents	
	Number	Percent
Initial Practice Location		
Illinois	48	60
Contiguous States	15	19
All Other States	17	21
Total	80	100%
Initial Community Size		
Less than 10,000	33	41
10,000 to 49,999	34	43
50,000 to 99,999	9	11
Greater than 100,000	4	5
Total	80	100%

the medical school location of the residency graduates. Illinois was the home state for 54% of the graduates, with an additional 19% indicating their home town was in a contiguous state. The remaining 27% reported a home town elsewhere in the United States or a foreign country. The population of the graduates' home towns was divided equally between the under 50,000 (50%) and over 50,000 (50%) categories. As for medical school location, 61% graduated from an Illinois medical school, 17% from a school in a contiguous state and 22% from all other locations.

A chi-square test was used to measure for a significant relationship between location of medical school and initial practice location ($X^2 = 13.73$ df1, $p < .001$) (Figure 2) and between home state and initial practice location ($X^2 = 20.21$ df1, $p < .001$) (Figure 3). Both relationships were found to be statistically significant, suggesting that both home state and location of medical school are strong predictors of initial practice location.

Discussion

A major objective in creation of the Southern Illinois University School of Medicine was to improve the retention of Illinois-trained physicians in Illinois. This study demonstrates that, to date, the majority of SIU family practice residency graduates have located their practices in Illinois. The SIU retention rate is somewhat higher than that experienced by a family practice residency program in a neighboring state.[2]

Another important finding of this study is the size of communities in which the graduates have established their practices. Many people feel that family practitioners are particularly suited for practice in smaller communities. Only 5% of the SIU graduates started practice in communities of over 100,000 population as compared with 33% of all other 1983 family practice resident graduates.

Also of significance is the finding that Illinois born and educated physicians are more likely to remain in the state to practice than those individuals from other states. This finding has implications for residency program directors responsible for selecting residents for their programs and public officials who wish to maximize the benefits to the citizens of Illinois. ◀

Figures 2 and 3

Figure 2

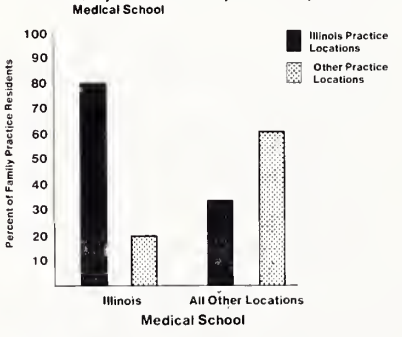
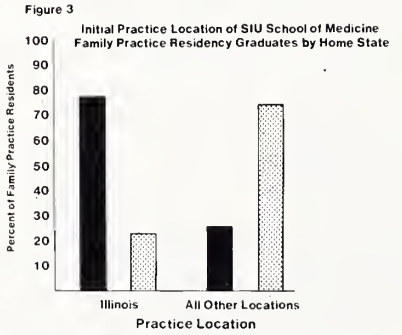


Figure 3



References

1. Cooper, J., Heald, K., Samuels, M., Coleman, S.: "Rural or Urban Practice: Factors Influencing the Location Decision of Primary Care Physicians," *Inquiry* 12:18-25, 1975.
2. Gjerde, C., Parker, L.: "Practice Selection Factors: A Follow-up of 74 Graduates of an Iowa Residency Program," *Family Medicine* 15:83-86, 1983.
3. LeFevre, M., Colwill, J.: "Practice Location as a Function of Medical School and Residency Location: Implications for Resident Selection," *Journal of Family Practice* 16:1157-1160, 1983.
4. Zetzman, M., Stefanu, C.: "Selecting a Community for Medical Practice: A Study of Factors, Characteristics, and Preferences Among Practicing Physicians, Family Practice Residents and Medical Students," *Texas Medicine* 73:86-92, 1977.
5. Diseker, R., Chappel, J.: "Relative Importance of Variables in Determination of Practice Location: A Pilot Study," *Social Science and Medicine* 10:559-563, 1976.
6. Hicks, L.: "Social Policy Implications of Physician Shortage Areas in Missouri," *American Journal of Public Health* 74:1316-1321, 1984.
7. Stefanu, C., Pate, M., Zetzman, M., Goldman, W., Jr., Brandt, E.: "Impact of a Family Practice Residency Program on Physical Location in Small Communities," *Southern Medical Journal* 73:1372-1374, 1980.
8. Stamps, P., Kuriger, F.: "Location Decisions of National Health Service Corps Physicians," *American Journal of Public Health* 73:906-907, 1983.

9. Wolinsky, F.: "Why Physicians Choose Different Types of Practice Settings," *Health Services Research* 17:399-419, 1982.

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Illinois Medical School Graduates

Initial Practice Location Choice

By John H. Summey, Ph.D., Vera C. Loftin, M.B.A., and Eugene B. Loftin III, M.D./Carbondale And Fairfield

Efforts to recruit physicians to Illinois have not been handicapped by a lack of physician interest. Findings indicate that 80.6% of Illinois medical students studied had considered locating in Illinois and that over 50% had considered locating in a rural area. The fact that only 8% ultimately chose to practice in rural Illinois indicates that many recruitment opportunities were missed. This article provides information on 15 important choice criteria that can be used to improve physician recruitment efforts.

Illinois medical school graduates have long been considered an asset to the state. However, many Illinois medical school graduates trained in publicly funded schools or financially aided by local communities leave the state when their training is complete.[1] The Medical Education Committee of the State of Illinois Board of Higher Education reported that Illinois ranked third in number of medical school graduates and 33rd in percentage of graduates who practice in the state where they attended medical school.[2] Illinois did attract the greatest number of new rural physicians between 1972 and 1977. However, 82% of these were not Illinois graduates but rather foreign medical school graduates.[3]

In 1982, recognizing the investment loss to Illinois taxpayers, and the potential effect on future medical education funding, the ISMS House of Delegates passed a resolution to encourage graduates of state medical schools to practice medicine in Illinois and to ask that ISMS councils, committees and other sources work to develop positive incentives for that purpose.[4] This charge was delegated to the Council on Education and Manpower, which organized a subcommittee on physician retention and recruitment.

The subcommittee decided that a marketplace analysis would best identify factors influencing practice location choice. Two objectives were identified. First, to determine the degree of interest or preference for establishing a medical practice in Illinois with reference to medical specialty, type of community preferred, and state of residence prior to age eighteen for respondent and spouse. The second objective was to determine those aspects of practice environment, personal goals, community characteristics, and family considerations influencing location decision.

Although information from the literature was limited, several references did touch on these topics, as well as state retention of medical school graduates. Hough and Marder concluded that medical school graduate retention was dependent on a physician's age, medical school, specialty, and the state's population and physician/population ratio. A high state population and a low physician/patient ratio yielded the highest graduate retention. There was no significant difference in retention based on state per capita income.[5] Watson found that admission of "in state resident" medical students improved retention.[6] Use of state scholarship incentives also enhanced retention.[7]

Ramsey, *et. al.*, found that location decision was made during internship or residency, although influencing factors may have developed much earlier. They also demonstrated that as early as medical school acceptance, an analysis of personal characteristics could predict the type of community in which a physician was likely to locate.[8]

The vast majority of pertinent literature focuses on rural versus urban practice setting choices. Studies point to the physician's home prior to age eighteen as the primary factor influencing practice location choice.[8-12] Eagleson and Tobolic found that family practice residents from rural backgrounds,

who did all of their practice training in their home state, were likely to practice in a rural area of that state.[13]

Steinwald, *et. al.*, found that the effect of rural perceptorships in family medicine was slight overall, but most pronounced on urban-reared physicians in non-primary care specialties.[14] Another influencing factor mentioned in the literature was an attractive group practice opportunity.[13] This implies that dissemination of information on non-solo practice opportunities in rural areas to urban-reared students could influence their choice in favor of a rural practice.

Highly specialized physicians have been shown to move by diffusion.[8,15] Ramsey, *et. al.*, found that physician distribution can be influenced by exposure to information. In this case, residents who were shown a U.S. map revealing practicing dermatologist density chose practice locations with few dermatologists.[8] Also, the probability of finding a particular type of physician in a community has been shown to be dependent, at least in part, on the size of the community.[16]

The effect of spouse preference for practice location was studied by Cooper. He reported that 81% of wives and 84% of husbands indicated that spouses had little or no effect on practice location choice.[12] This finding was in agreement with Diesker's analysis in which residents ranked acceptability to spouse below practice coverage and hospital facilities but above geographic location.[17] More recent studies, however, have suggested the spouse's role is more important.[18,19]

Methodology

Illinois medical school graduates in second and third year post graduate training programs were surveyed. Graduates represented each of the public and private Illinois medical schools: Chicago Medical School; Loyola-Stritch School of Medicine; Northwestern University Medical School; Rush Medical School; Southern Illinois University Medical School; University of Chicago Medical School; and the University of Illinois Medical School campuses (Abraham Lincoln, Peoria, and Rockford).

This study was based on ideas collected both from a review of the literature and from focus interviews with second and third year medical residents. It was designed to yield data in the areas of: (1) degree of Illinois medical school graduate interest in establishing a practice in Illinois, and (2) factors influencing location preference such as personal background and goals, practice environment, medical specialty, community characteristics, and family considerations. A questionnaire was mailed to a probability sample of 1092 medical residents. A response rate of 469 readable questionnaires or 43% was achieved through two mailings.

Methods of analysis were descriptive in nature and included statistical tests for association, frequency tables, and cross tabulation analysis. A weighted ranking procedure was also used to evaluate the relative importance of various location choice factors.

Results

Interest in Practicing in Illinois

In contrast to the relatively low retention rate for physicians trained in Illinois, (32.5% in 1980) the findings of this study indicate that a high percentage (80.6%) of the residents had seriously considered Illinois as a practice location. An indication of the strength of the residents' interest in Illinois as a practice location is the finding that 40.3% of those residents who listed Illinois as their first preference also listed it as their second choice. Only 16.3% of the residents who listed another state as their first preference listed Illinois as their second choice. Data also indicate that public medical school graduates have a greater preference for practicing in Illinois than do private school graduates.

Effect of Spouse

This study found that 58.4% of the physicians whose spouse's residence prior to age 18 was in Illinois considered Illinois first in their list of preferred practice locations (significant at $p = .001$). When the spouse's primary residence before age 18 was not Illinois, Illinois was the location of first choice for only 26.4%, even if the physician had primarily resided in Illinois before the age of 18 (significant at $p = .001$). These results support a conclusion that the physician's spouse may in fact now represent an important component of the location choice decision.

Type of Community Preferred

Most states are interested in securing physicians to practice in rural communities. The survey data indicate that 50.3% of the residents from private medical schools and 53.9% of those from public medical schools, whose practices were *not* going to be located in a rural area, had seriously considered practicing in a rural location. The actual preference for urban, suburban, or rural communities as a practice location, however, varies with medical school. These results appear in Table 1.

The data were examined to see if

Table 1
Medical School by Type of Practice Location Community Preferred
(Row percents reported)

	Urban		Suburban		Rural	
	#	%	#	%	#	%
Chicago Medical	20	60.6	10	30.3	3	9.1
Loyola Stritch	18	40.0	20	44.4	7	15.6
Northwestern	29	56.9	16	31.4	6	11.8
Rush	22	66.7	8	24.2	3	9.1
Southern Illinois	13	34.2	9	23.7	16	42.1
Univ. of Chicago	32	64.0	15	30.0	3	6.0
Univ. of Illinois	53	50.0	34	32.1	19	17.9
Totals	187	52.5	112	31.5	57	16.0

there was any association between the type of community preferred and the choice of Illinois versus other states for a practice location but no statistically significant association was found (at $p = .05$).

Location Criteria

Both private and public school residents were asked to rank three global choice criteria in order of importance: (1) community location, (2) type of practice opportunity, and (3) community size. There were no statistically significant differences ($p = .05$) in these rankings by second or third year residents, or public and private medical school graduates.

To gain further insight, subjects were asked to rank their three most important choice criteria from within each of four overall categories: (1) practice environment, (2) personal goals, (3) community characteristics and (4) family considerations. On the research instrument these categories included seven to fourteen possible criteria. A test for differences in ranking by second and third year residents indicated no statistically significant difference (at $p = .05$). The two groups were combined and the results, as determined using a weighted ranking procedure, appear in Table 2. They indicate that there are some slight, but potentially distinct, differences between public and private residents' rankings of location choice criteria.

Table 2
Considerations in Choosing a Practice Location in Order of Importance Within Categories

CATEGORIES	PRIVATE SCHOOL GRADUATES	PUBLIC SCHOOL GRADUATES
Practice Environment	1. Availability of practice opportunities	1. Availability of practice opportunities
	2. Specialized diagnostic tools	2. Specialized diagnostic tools
	3. Access to staff at university hospital	3. Ease of arranging coverage
Personal Goals	1. Access to cultural activities	1. Access to recreational facilities
	2. Access to recreational facilities	2. Access to cultural activities
	3. Opportunity for financial success	3. Opportunity for financial success
Community Characteristics	1. Close proximity to large city	1. Close proximity to large city
	2. Friendliness of community	2. Friendliness of community
	3. Close proximity of a university	3. Preferred climate
Family Considerations	1. Career opportunities for spouse	1. Good academic programs in schools
	2. Good academic programs in schools	2. Career opportunities for spouse
	3. Cultural development opportunities for family	3. Recreational facilities for family

Current State of Physician Recruiting

The key question as asked by the Illinois State Medical Society Council on Education and Manpower is: Why has Illinois had a low level of success in retaining its medical school graduates? By creating a market place analogy, in which the community represents a product and the physician represents the consumer, some possible insight might be achieved.

When the supply of a product (in this case available practice locations) exceeds the demand, the consumer can pick and choose. The choice is made on the basis of information about the benefits that each product has to offer. It appears that the majority of Illinois medical school graduates have neither received any information about, nor been contacted by, any Illinois cities or towns. These physicians may not have considered a large number of Illinois communities that might have met their needs and expectations.

When asked if they had seriously considered Illinois as a practice location, 80.6% of the residents answered yes. In contrast to this high level of interest, only 16.7% had been contacted by Illinois cities during medical school and only 18% were contacted or had contact maintained with them during their residencies. For some reason, the residents were also not aggressive in seeking practice opportunities in Illinois during their residencies. Only 12.8% had initiated any contact with Illinois cities or towns. An important step toward increased physician retention, therefore, should be a broad-based effort to inform residents of the opportunities that exist in Illinois communities.

In addition to, or as a result of, the lack of community contact, the physicians indicated a lack of information about practice opportunities in Illinois communities. Sixty percent of the residents surveyed received no information at all regarding practice opportunities in

Illinois. An additional 20.5% received either inadequate or only somewhat adequate information.

Conclusions

Graduates of Illinois medical schools appear to have a strong interest in establishing their initial medical practice in Illinois. Data indicate that 80.6% of the graduates had seriously considered Illinois and 43.9% had listed Illinois as their first choice. The strongest interest came from public school graduates, with 50.3% choosing Illinois as their first choice. The most likely candidate for establishing a medical practice in Illinois was a public medical school graduate whose primary residence prior to age eighteen—and that of the spouse—had been in Illinois.

When given a choice of three primary criteria for a practice location, community location was first, followed by type of practice opportunity, and community size. Subsequent analysis indicated that community location in close proximity to a large city, availability of practice opportunities, access to cultural and recreational activities, career opportunities for a spouse, and good academic programs in local schools all played potentially key roles in the choice of a practice location.

The problem facing communities in Illinois is not one of generating interest among medical school graduates. Rather, it is one of determining how to best capitalize on the interest that already exists. A broad-based effort to inform residents of the opportunities that exist in Illinois communities, would be an important step toward increased physician retention.

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The members of the subcommittee on physician recruitment and retention who contributed to this project were Gerard Cerchio, M.D., Paula Olen-Mikrut, M.D., John Diveris, M.D. and Steven Perrigo.

References

1. Loftin, E.B. (letter), Steiber, S.R. (reply): "Physicians Who Move," *JAMA* 249:1267-1268, 1983.
2. Report of the Medical Education Committee submitted to the State of Illinois Board of Higher Education; September 8, 1982.
3. Madison, D.L., Combs, C.D.: "Location Patterns of Recent Physician Settlers in Rural America," *J of Community Health* 6:267-273, 1981.
4. Wayne County Medical Society: "Obligation of Physicians for Education Subsidies, Illinois State Medical Society House of Delegates," *IMJ* 161:429, 1982.
5. Hough, D.E., Marder, W.D.: "State Retention of Medical School Graduates," *Journal of Medical Education* 57:505-513, 1982.
6. Watson, C.J.: "An Empirical Model of Physician Practice Location Decisions," *Computers and Biomedical Research* 13:363-381, 1980.
7. Newhouse, J.P., Williams, A.P., Bennett, B.W., Swartz, W.B.: "Where Have All The Doctors Gone?" *JAMA* 242:2392-2396, 1982.
8. Ramsey, D., Krasner, M., Fox, B.: "Improving the Geographic Distribution of Physicians: The Role of Information and its Dissemination," *JAMA* 242:1891-1894, 1979.
9. Bible, B.L.: "Physicians' View of Medical Practice in Non-Metropolitan Communities," *North Carolina Med J* 21:69-101, 1979.
10. Yett, D.E., Sloan, F.A.: "Migration Patterns of Recent Medical School Graduates," *Inquiry* 11:125-142, 1974.
11. Heald, K.A., Cooper, J.K., Coleman, S.: "Choice of Location of Practice of Medical School Graduates: Analysis of Two Surveys," Rand-American Medical Association, R-1477-HEW, 11-74.
12. Cooper, J.K., Heald, K.A., Samuels, M., Coleman, S.: "Rural or Urban Practice: Factors Influencing the Location Decision of Primary Care Physicians," *Inquiry* 12:18-25, 1975.
13. Eagleson, B.K., Tobolic, T.: "A Survey of Students who Chose Family Practice Residencies," *The Journal of Family Practice* 6:111-118, 1978.
14. Steinwald, B., Steinwald, C.: "The Effect of Preceptorship and Rural Training Programs on Physician Practice Location Decisions," *Medical Care* 13:219-229, 1975.
15. Steiber, R.: "Physicians Who Move and Why They Move," *JAMA* 248:1490-1492, 1982.
16. Aaron, P.R., Somes, G.W., Marx, M.B. "Relationship Between Traits of Kentucky Physicians and Their Practice Areas," *Inquiry* 17:128-136, 1980.
17. Diseker, R.A., Chappell, J.A.: "Relative Importance of Variables in Determination of Practice Locations: A Pilot Study," *Soc. Sci. and Med* 10:559-563, 1976.
18. Skipper, J.K., Gliebe, W.: "Forgotten Persons: Physicians' Wives and Their Influence on Medical Career Decisions," *J Med Ed* 52:764-766, 1977.
19. Cuca, J.M.: "1978 U.S. Medical School Graduates Practice Setting Preferences, Other Career Plans, and Personal Characteristics," *J Med Ed* 55:465-468, 1980.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Low dose aspirin therapy benefited angiotensin-sensitive primigravida patients vulnerable to pregnancy-induced hypertension and preeclampsia. Angiotensin-II sensitivity was ascertained by testing 46 healthy women in the 28th-week of pregnancy with an intravenous infusion of angiotensin-II-amide in glucose. This was followed either by placebos or 60mg aspirin daily. Only two women in the aspirin group had mild pregnancy-induced hypertension. The placebo-treated group exhibited four instances of hypertension, seven of preeclampsia and one case of eclampsia. Low dose aspirin may restore imbalance in prostacyclin-thromboxane levels, which may be etiologic in patients with tendencies to pregnancy-associated preeclampsia and hypertension. (Wallenberg, C.S., *et al: The Lancet* 8471:1, 1-3, 1986)

An analysis of 903 patients after a myocardial infarct determined that the use of digoxin did not significantly increase mortality. A mortality rate of 28% in the digoxin-treated patients as compared to an 11% rate in those patients not requiring digoxin was attributed to the severity of cases involved requiring digoxin. (Muller, J., *et al: N Engl J Med* 314:5, 265-71, 1986)

Genetic influences are important factors in obesity. Five hundred forty adoptees were evaluated as being in a weight class—thin, medium, overweight or obese—and compared to their mother, father, adoptive mother and adoptive father. Indexes showing cumulative distributions of body mass indicate a strong relationship between the body mass of biologic parents (mothers: $P < 0.0001$; fathers: $P < 0.02$) across all four body mass categories. The family environment alone had no apparent effect. (Stunkard, A., *et al: N Engl J Med* 314:4, 193-8, 1986)

The National Academy of Sciences Food and Nutrition Board has developed recommended dietary allowances for infants, children and adults and is studying the needs of older citizens. Their findings indicate that Vitamin D and calcium absorption decline substantially with age. Renal function may decline by 20%-30%. Those older than 70 show a decreased protein absorption or metabolism, and resulting leaner body mass. The older population exhibits greater heterogeneity, making it difficult to create standards. (Schneider, E., *et al: N Engl J Med* 314:3, 157-60, 1986)

The effect of electrical stimulation of the sciatic nerve on the gastrocnemius muscles was studied in rats with normal nerves and with partial denervation. Findings indicated that two hours of stimulation per day significantly increased the muscle mass, and the twitch and tetanic tensions, but did not affect contraction time. Four hours and eight hours of electrical stimulation yielded similar responses. (Herbison, G., *et al: Arch Phys Med Rehab* 67:2, 79-83, 1986)

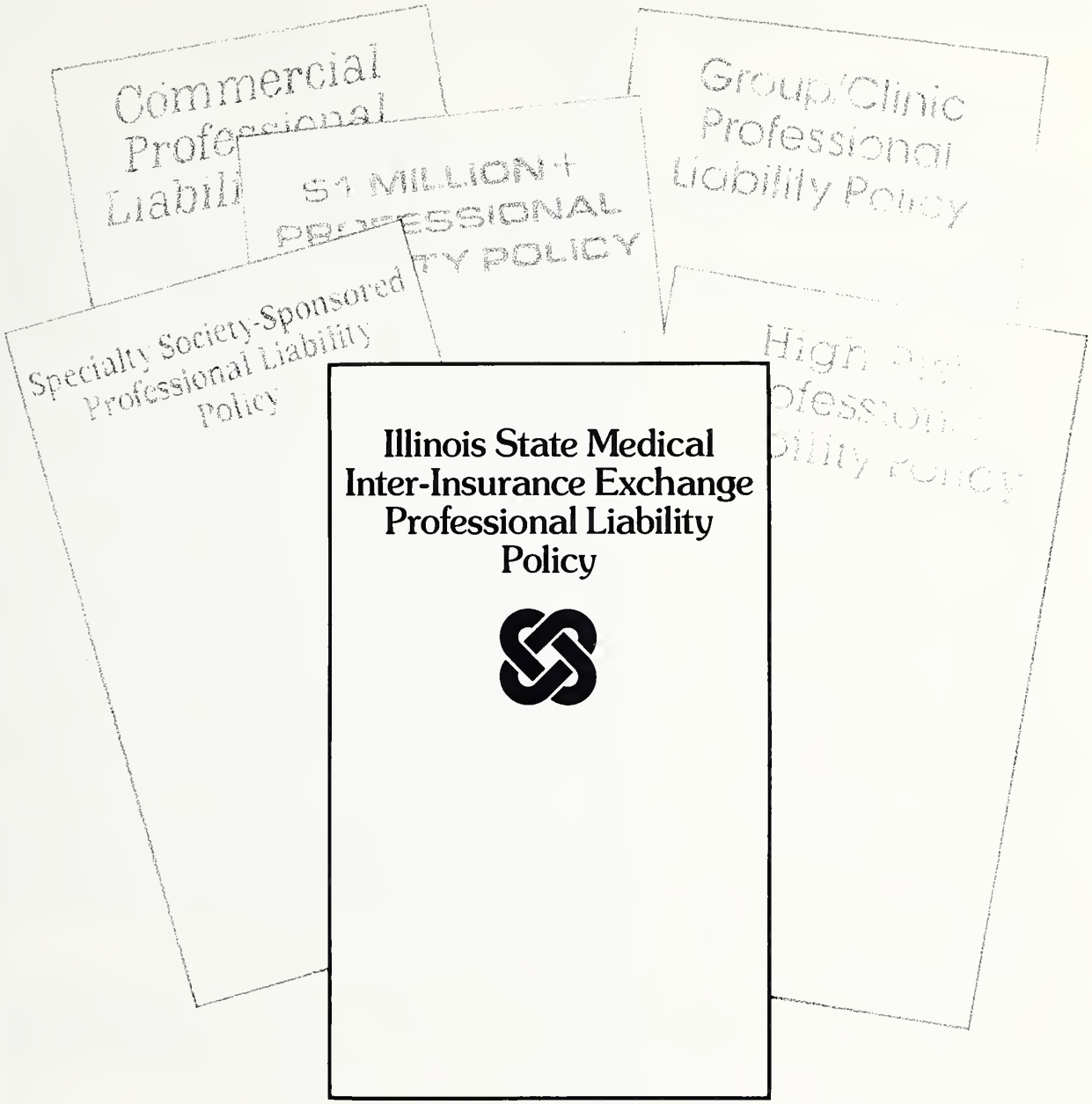
The American Medical Association Council on Scientific Affairs indicates that snuff or chewing tobacco may adversely affect reproduction, longevity, the oral cavity and the cardiovascular system. They recommend well-planned studies and restrictions in advertising, as applied to cigarettes. (*JAMA* 255:8, 1038-1044, 1986)

Elderly patients frequently present with atypical symptoms making diagnosis of disease difficult. Infectious diseases, particularly of the bladder and lungs, are a major source of morbidity. The authors suggest the nitroblue tetrazolium dye test to assist in the diagnosis of infectious diseases in the elderly. Only stimulated neutrophils, as a response to phagocytosis, bacterial toxins and interaction with opsonized surfaces, take up this dye. (Gulati, R., *et al: Ger Med Today* 5:2, 79-85, 1986)

Patients with active Epstein-Barr viral infections may present with unusual neurologic manifestations and minimal systemic findings of infectious mononucleosis. The authors present two atypical cases with neurologic symptoms. The first was a 14-year-old female with acute right hemiplegic migraine headache, hemiparetic weakness and left sided paresthesia. The second patient was a 23-month-old female with a two-week history of chorea and gradual mental deterioration. (Leavell, R., *et al: Arch Neurol* 43:2, 186-88, 1986)

Pulmonary emboli generally arise from deep venous thromboses in the legs which are clinically difficult to diagnose. Venography, a highly accurate diagnostic procedure, is invasive, expensive, uncomfortable, and may lead to an inflammatory thrombophlebitis. The authors suggest the use of Doppler ultrasonography and a pulse volume recorder. There were no false-positive noninvasive tests that showed a normal venogram. (McCandless, M., *et al: Cleveland Clin Quart* 52:4, 555-60, 1985)

The dental service at the Mayo Clinic used a dental implant to replace missing teeth in a selected group of 70 patients. The implants consisted of a dental prosthesis with an anchoring screw component. In 358 osseointegrated dental fixtures, the overall success rate was 98%. The associated complications were minimal and easily resolved. (Laney, W., *et al: Mayo Clin Proc* 61:2, 91-7, 1986)



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A Dangerous Mix

Alcohol, Drugs and Medical Students

By Alan J. Scharrer, MS IV/SIU School of Medicine

Physician impairment is becoming an increasing concern to the medical profession. Increased competition, soaring malpractice rates, astronomical medical education debts, rapidly changing payment systems and the near daily innovations in medicine contribute to a stressful professional environment. In fact, according to the American Medical Association, one out of ten physicians, sometime in their careers, will become impaired. It is vital that this problem be addressed by all members of the medical profession.

Impaired physicians who have been asked when their problems first began almost universally state that their medical school days provided the "right" mixture of stress, insufficient social life and lack of support to allow for development of destructive, dysfunctional coping mechanisms which eventually lead to impairment. It is obvious, then, that impairment must be dealt with at the medical school level if any headway is to be made in the prevention of this disease.

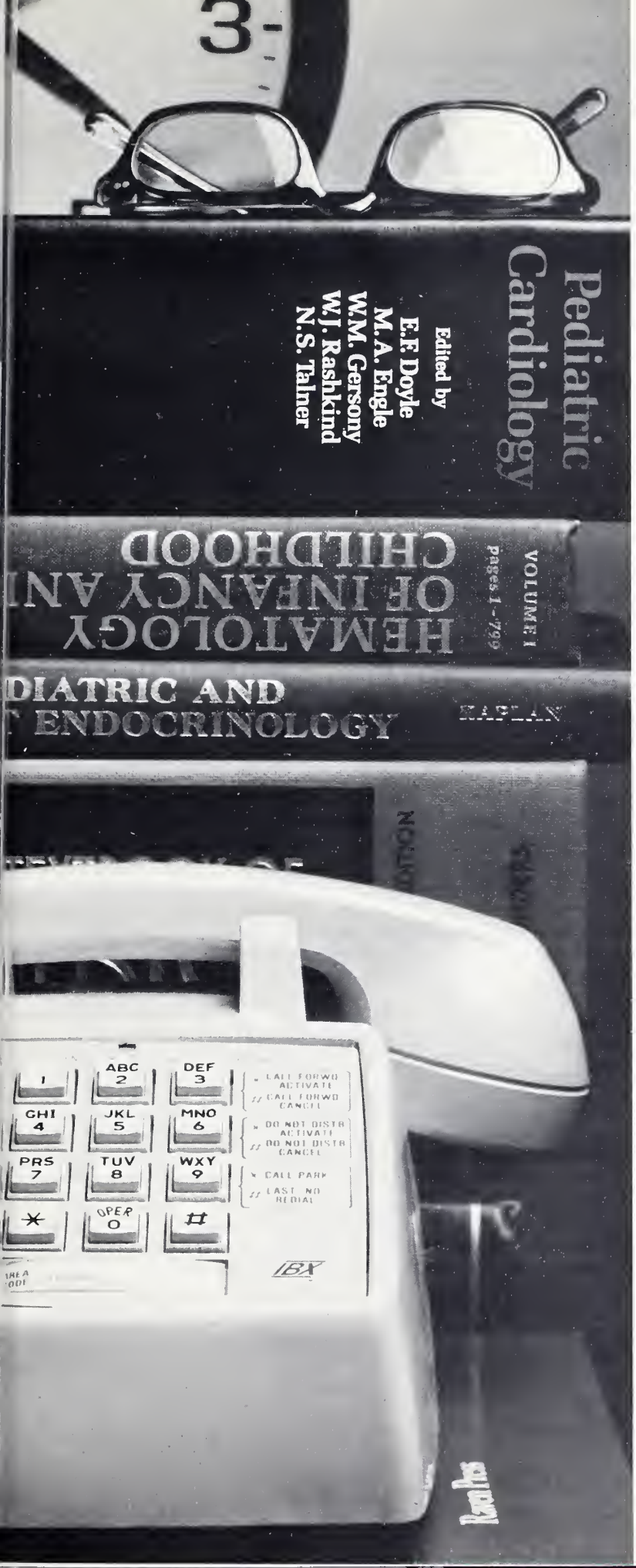
Student leaders of the ISMS-MSS are very familiar with conferences addressing the "hazards" of a medical education. Unfortunately, these excellent seminars reach only a very small proportion of the total number of medical students in Illinois. It is unlikely that those students prone to impairment recognize the need for these programs and attend them. It is important to reach all medical students, especially those predisposed to impairment. Their classmates will benefit from a better understanding of this problem and be better able to recognize its signs and symptoms in their colleagues or even in themselves. It is students who are most likely to become aware of developing problems in their classmates, so it must be students who initiate actions to help each other.

What is being suggested is simply that conferences addressing the topic of medical student impairment be held at least annually at each medical school in Illinois. These seminars would be specifically tailored to address the unique problems and stresses faced by students at that particular institution. A very personalized program would be better understood by the audience. It is especially important that first and third year students be in attendance. These are the traditional transition points in medical education and therefore, the most stressful. Finally, the program must address the topic of what counseling and treatment is available at that particular institution. Too often, counselors dealing with medical students are not readily identifiable by those in need. What is needed is a simple listing of faculty who counsel with emphasis that confidentiality will be maintained.

No attempt should be made to formally organize these counselors as the lack of organization serves to increase confidentiality. It would be best if these faculty members could be present during the seminar to give a brief summary of their counseling styles. It must be noted that, when undertaking the planning of this project, the department chairmen should be notified as early as possible of tentative dates so that they may plan their schedules accordingly. This will probably be the most difficult task in the organization of this conference.

An excellent resource to assist in the planning of this seminar is the ISMS Committee for the Impaired Physician. If this group co-sponsors the event, it may be better accepted by faculty and administrators. The meeting can also provide an opportunity to acquaint students with the Committee, which is a valuable resource. Physician assistance committees are a proven means to assist impaired colleagues. The ISMS Committee is available to any physician or medical student who is experiencing impairment. These students—or their concerned friends—should be encouraged to contact the ISMS Physician Help Line at 312-580-2499.

One final point: the students must be the driving force behind the organization of this conference. If we, as students, are to make caring physicians, we must each make a personal commitment. We cannot neglect classmates in need of help. This seminar can not only help fellow students, but also prove to the medical educators that there is a need to incorporate this topic in the current curriculum. After all, impairment is not a disease that will be cured by treating symptoms. It can be prevented or, at least controlled, if we are knowledgeable about, and sensitive to, its insidious, destructive nature. ◀



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Generosity of Spirit

The following remarks are excerpted from a speech given by Mrs. Harlan English in 1983 when she received the ISMS Auxiliary's Humanitarian Award. Mrs. English, of Danville, Illinois, was president of the ISMSA in 1952-53, and served as president of the AMA Auxiliary in 1961-62.

As I planned for this day, I wanted to thank you by saying something useful. I could not presume to talk about the great motivating laws: work, beauty, truth and love. I hope you live by them. Nothing will be right if you do not. But I do know some little "rules of thumb" to pass along. They aren't original or very grand but they seem to help make the world go around. I repeat them to refresh memories and prick consciences.

1. When you can do something and somebody wants you to do it—then do it.
2. Don't fear stress. Learn that stress point beyond which you cannot work, observe it, and stress will be a friend. Stress stimulates you physically and emotionally. You need it to do the work with which you will buy your dignity.
3. Keep your curiosity. (Your body will die if you stop feeling hunger and thirst, and your mind will die if you lose your curiosity.)
4. Give yourself security by giving it to those you touch.
5. Next let me warn you. Your most dangerous foe will be apathy. This means that your efforts must be persistent and carry with them enthusiasm, for enthusiasm spells the difference between mediocrity and accomplishment: more importantly, it is infectious.
6. Remember that charm is woman's strength. It gives her the power to effect work without using brute force.
7. Finally, there is the rule of happiness. Happiness is a habit; learn to cultivate it. A big stomachache or a big heartache can interrupt happiness, but neither can destroy it. Even heartaches that can't really be mended seem to yield to the habit of finding happiness in doing things in love and in the memory of love. Don't lose that habit.

So, I say to you, learn to live by the great laws and these little rules of thumb.

For honors and opportunities which have come back to each person, I believe there is repayment—a magic gift that we must make to co-workers and those who follow us. It is the gift of encouragement. I am not referring to the proverbial "pat-on-the-back." Belief in a person is not so honestly revealed in words as it is in the assumptions on which one habitually acts. I am thinking about the encouragement you give to others when you show appreciation of their efforts, when you share opportunities to learn, to make decisions, to act: when you show confidence in them. The development of informed co-workers, the piling up of tentative ideas are indispensable parts of long term planning.

I am not suggesting that we should each be "the teacher." Teaching all too often results in a mere reflection of what has been projected mentally. I plead for generosity of spirit and an honest effort to help those who work with us, those who will follow us, to be knowledgeable, to believe in themselves, and in their ability to carry on wisely and well.

As a tribute and with great thankfulness to those who gave us all that we have today—all that we are: let us each pledge to give the magic gift, encouragement. ◀

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ANNOUNCES

Lithotripsy for Kidney Stone Patients

The Medical Center is pleased to advise the Chicago medical community that its Kidney Stone Treatment Center is accepting patients who can benefit from treatment on the Dornier Extracorporeal Shock Wave Lithotripter, which is now fully operational. Among members of the department of urology already trained and certified in this non-invasive procedure are Malachi J. Flanagan, M.D., Charles F. McKiel, Jr., M.D., and Dennis A. Pessis, M.D.

The protocols established for operation of the lithotripsy program at Rush are designed to keep all referring physicians informed of their patient's progress at all times and to assure that patients are returned to their physician's care upon completion of treatment. We will also provide the physician with a full report, in writing, of the results of treatment.

Certain diagnostic procedures, including x-rays, are required before a patient may undergo lithotripsy. At such time as physicians contact the Kidney Stone Treatment Center to discuss the needs of their patient, they will be advised of what information is needed so that they can make arrangements for appropriate tests. Or, if they prefer, such testing can be done at the Medical Center.

We look forward to serving you and your patients and encourage you to contact the Kidney Stone Treatment Center (312/942-8261) for additional information.

The Kidney Stone Treatment Center
1753 West Congress Parkway Chicago, Illinois 60612



A Good Health Resource of Rush-Presbyterian-St. Luke's Medical Center

The Time is Now and the Solution Is You

By Robert R. Hartman, M.D.
ISMS Liaison and AAMA National Advisor

Involvement in the American Association of Medical Assistants has greatly enriched my professional and social life. I first became acquainted with the organization when I was asked to serve as advisor to our newly organized chapter, and I was immediately impressed with the association's potential. Six years ago, I was delighted to be named liaison between the Illinois State Medical Society and the Illinois Society, AAMA. Two years later, the Illinois Society nominated me to fill the vacancy created by Dr. John Wright's retirement as national advisor. Dr. Wright, whose long service at all three levels of membership is well recognized, had served as my mentor when I first became active at the state level; all of the physician liaison members look to him for advice and leadership. Dr. Wright urged me to accept national responsibilities.

In reviewing my activities for the AAMA, many events come to mind. These include national conventions, which were always exciting and sometimes controversial; council meetings and board meetings, where the policies initiated by the House were implemented; and the deliberations of the curriculum review board. Each has broadened my knowledge of and respect for the organization. My visits to schools as a survey team member were also enjoyable. But activities at the state level are those I remember with the greatest pleasure. One comes to know people better and to develop greater affections at the local level; there is a greater sense of belonging and, for the most part, a greater sense of harmony.

My concerns relative to the association are few, but deep. Membership continues to fall and overhead is difficult to control. Establishment of a national image continues to be a problem, despite the efforts of professional public relations firms. The cost of tri-level membership is a deterrent to some. This relates to the fact that employers all too often do not recompensate members at a scale above that of non-members, or recognize and reward efforts to become certified. The national office must maintain an adequate work force in order to provide services, but this is difficult given the narrowing membership base. Increasing dues seems the most effective way to accomplish this; more funding would also be helpful to the journal, which relates the multiplicity of membership activities.

The concept of regional educational conferences rather than national conventions is intriguing. Certainly they can be more readily accommodated in smaller communities, which usually means smaller costs. The shorter distances to be traveled should increase total overall attendance. Those who would prefer to maintain the national convention seem to feel that there is a greater opportunity to arrive at a consensus with all areas assembled, rather than at a meeting devoted entirely to the business of the association. Also important, although less critical, is the lost opportunity to visit "the big city" and the ability to socialize with old friends from distant points. We can hope that these differences will resolve with time. Action taken at the Lexington convention calls for an *ad hoc* committee to evaluate the regional meetings—and an annual meeting in 1988.

To enumerate problems without offering solutions is not too often helpful. My thoughts are not all encouraging. Many organizations are experiencing membership problems. Those which are most successful in growth and influence seem to share a few important attributes. First, they share a well-defined goal or purpose. Second, they reflect a sound, solid recognition within their area of performance. Third, they have an enthusiastic and dedicated membership, imbued with an almost evangelical commitment for both recruitment and publicity.

Ultimately, the success or failure of our organization will not be determined by how well national publicizes our activities, or how state societies take on controversial matters, or how often chapters meet. Success or failure will be determined by the extent to which the organization satisfies the needs of the individual member. Is the material received from the association, society or chapter pertinent? Is there a return commensurate with effort expended? Will the individual feel that he or she will be missed if they don't attend and, perhaps even more important, will they miss something important if they fail to participate? Local chapter success makes for state society prosperity and enthusiasm, both of which are essential for national to continue. Each of us must be a driving, active participant if we are to succeed. The problem is complex but the solution is clear. The time is now and the solution is you.

Information regarding the Illinois Society and/or medical assisting can be obtained from Ehlma Garcia, CMA, EMT-A, President, Illinois Society, 6134 S. Tripp, Chicago, IL 60629; Robin Bluestein, CMA-C, Co-Chairman, Public Relations Committee, 2247 W. Estes #2, Chicago, IL 60645; or Catherine M. Hill, CMA, Co-Chairman, Public Relations Committee, 900 S. Plum Grove Road, Palatine, IL 60067.

Doing Something About "Bad Doctors"



How many times in the last year have we heard plaintiff attorneys declare that the best way to solve the malpractice problem is to get rid of "bad doctors"? We all know that this oversimplifies the medical liability problem, since many good doctors are sued. But it does underscore the importance of improving the medical disciplinary system. The subject is so complex that the Governor appointed a special task force to study it. As of this writing, members of the Task Force on Medical Discipline had finished their work and had forwarded a final report to the Governor's office.

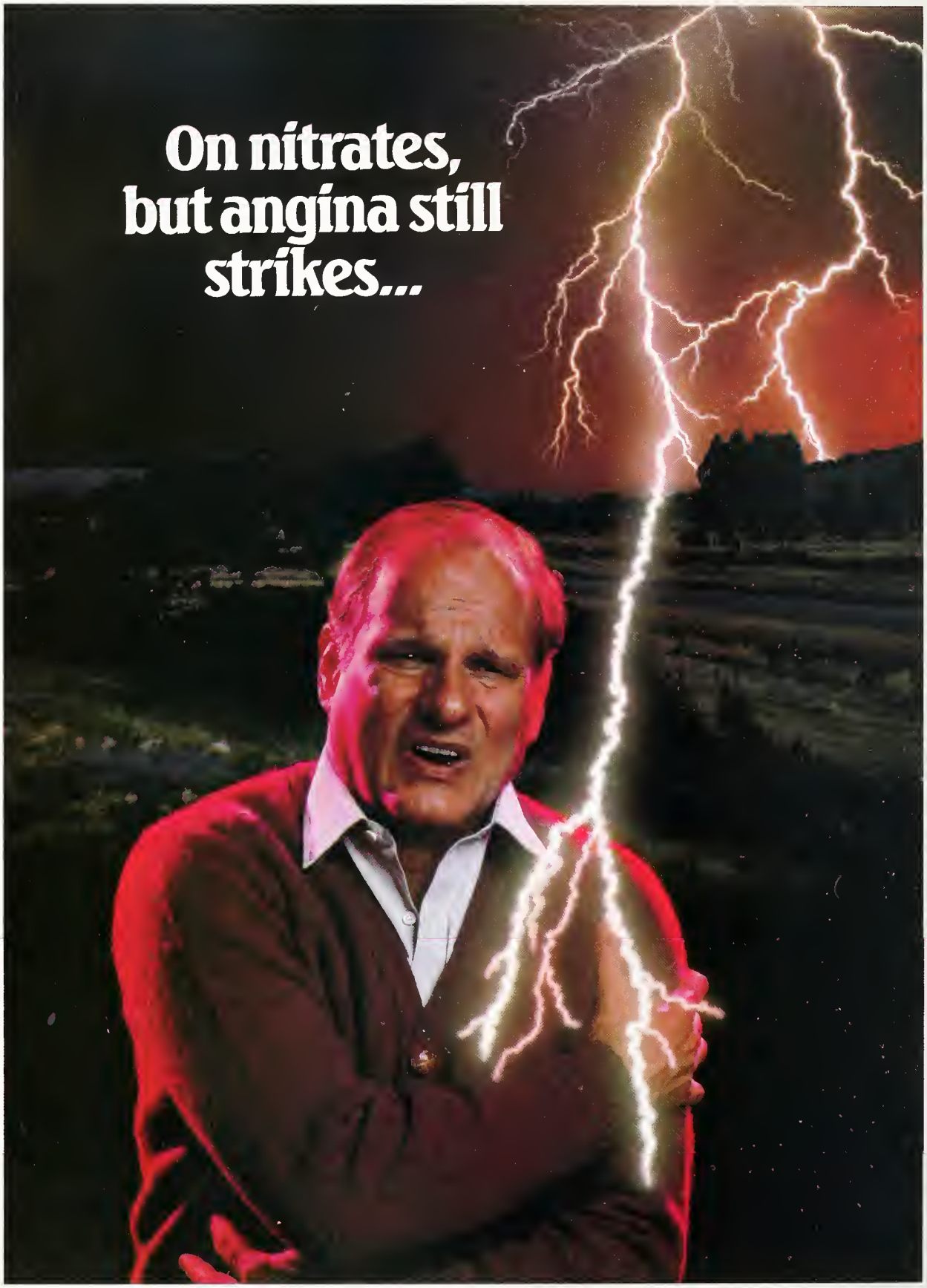
Problems in the present system must be addressed. Any solutions must meet the needs of both the small counties, where only a few doctors are available for peer review, and the large counties, where physician availability is not a problem but other frustrations remain. Peer review committee members have difficulty if the offending physician is a relative, friend or member of the same group. They sometimes may be accused of "witch-hunting" to get rid of their competition. They become discouraged when they do their job, and report the action to the Medical Disciplinary Board, but nothing happens. When this occurs, those who give their valuable time to do what must be done become disenchanted with the process and feel like giving up.

I have always had a problem relating to individuals in our profession who charge excessive fees or seek to enrich themselves by taking advantage of the vulnerability of the very ill and those who are dying. These are people operating on the fringe of ethical conduct who have not yet been involved in the medical disciplinary system and who are a weakness in the profession we must continually answer for. Their activities are among the things that the special task force has been addressing.

I think we all agree that improvement is necessary, and we must support it for our own sakes. Effective changes in the system will also provide a response to critics who say that we do nothing about "bad doctors." It is important that each of us do our part to support peer review at the local level. I urge all the members of ISMS to make a strong personal commitment to improve medical discipline. We must each be willing to work actively to sweep the incompetent doctors out of medicine. ◀

Jere E. Freidheim, M.D.

Jere E. Freidheim, M.D.
President


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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was prepared by Richard Gray, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

A previously healthy 64-year-old woman presented with vague epigastric discomfort. A firm abdominal mass was palpated. Abdominal computed tomography demonstrated a pancreatic mass (Figure 1).

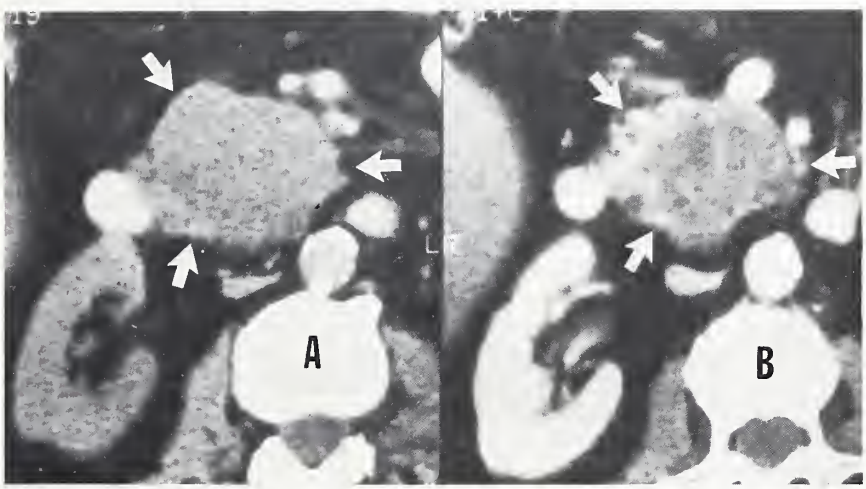


Figure 1—Computed tomography of pancreas. A: Mass (arrows) in head of pancreas. B: Following intravenous contrast material injection, delicate septae are visible within the mass (arrows).

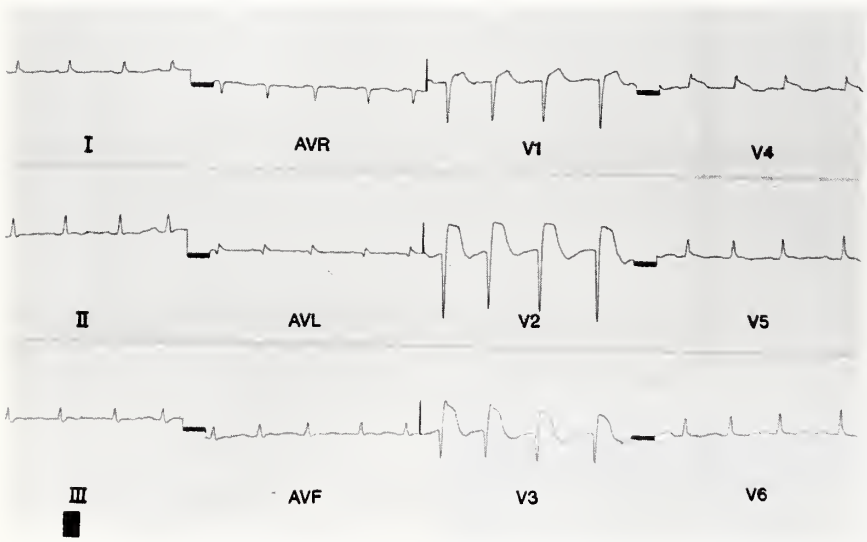
Your diagnosis?

(1) Adenocarcinoma of the pancreas
(2) Microcystic adenoma of the pancreas
(3) Pseudocyst
(4) Islet cell tumor
(5) Mucinous cystic neoplasm of the pancreas

(Continued on page 314)

EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient was a 72-year-old woman who came to the emergency service with a 15-hour history of back pain and bilateral shoulder and arm pain. The pain had awakened her from sleep but caused her no immediate concern. She had taken acetaminophen throughout the day for persisting pain without relief. The patient developed nausea, became diaphoretic, and then came to the emergency service. She denied previous hospitalizations, medicines, or any prior medical problems excepting peptic ulcer disease many years before. Her blood pressure was 138/80mmHg with a pulse of 96 beats per minute. She had an atrial gallop with a normal lung exam. Two milligrams of morphine sulfate was administered intravenously. Later her blood pressure fell to a systolic of 50mmHg and dopamine and fluids were started. A pulmonary artery catheter was inserted and this twelve lead ECG was obtained.

Questions:

1. The twelve lead ECG shows:
   A. Accelerated idioventricular rhythm.
   B. Paroxysmal ventricular tachycardia.
   C. An acute anteroseptal myocardial infarction.
   D. Cycle dependent complete left bundle branch block.
   E. Atrial fibrillation.

2. The following statements could apply to the management of this patient:
   A. Evaluate the patient for hypovolemia.
   B. Re-examine the patient for evidence of cardiac mechanical defects, *e.g.*, mitral regurgitation or ventricular septal defect.
   C. Measure cardiac output or cardiac index.
   D. Treat any acidosis and hypoxia.
   E. All of the above.

(Continued on page 317)

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JUNE

OBGYN/Family Medicine

Update in OBGYN

For: OBGyn and family physicians. Course, June 13-14, Lexington, KY. **Sponsor:** University of Kentucky College of Medicine, Office of Continuing Education, 132 COM Office Bldg., Lexington, KY 40536. **Fee:** $130. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP: 10. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

OBGYN/Family Medicine/Urology

Medical Seminar-at-Sea (North Cape Cruise)

For: Interested physicians. June 21-July 3, North Cape. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $500. **Credit:** Category 1: 48 hours. **Contact:** Charles Osborne, Ed.D.. **Phone:** (217) 782-7711.

Chicago Area Schools of Medicine Obstetrics and Gynecology Review

For: OB/Gyn's. Course, June 16-21, Chicago, IL. **Sponsors:** Seven medical schools of Illinois, c/o The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $550. **Reg. Limit:** None. **Credit:** Category 1: 42 hours; ACOG: 42 Cognates. **Contact:** Mary Ann Dillon. **Phone:** (312) 926-1056.

Otolaryngology

Chicago Temporal Bone Dissection Course

For: Otolaryngologists/residents. Course, June 2-6, Hinsdale, IL. **Sponsors:** Department of Otolaryngology for Northwestern, Loyola and Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521. **Fee:** $900 (physicians), $600 (residents). **Reg. Limit:** 8. **Credit:** Category 1: 40 hours. **Contact:** Cheri Jones, M.P.H. **Phone:** (312) 887-2400.

Endoscopic Sinus Surgery

For: Otolaryngologists. Workshop, June 16, Chicago. **Sponsor:** The University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $400. **Reg. Limit:** 60. **Credit:** Category 1: 7 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Pathology

DNA Hybridization in Surgical Pathology

For: Pathologists. Lecture, June 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** (CME credit is for members only) Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Department of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Cardiology

Cardiac Rehabilitation

For: Interested health professionals. Workshop, June 16-20, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Cardiac Rehabilitation for Children

For: Interested health professionals. Workshop, June 27-28, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $225. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Fitness/Weight Control

Fitness and Weight Control

For: Interested health professionals. Workshop, June 9-13, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Exercise

Graded Exercise Testing (GXT)

For: Interested health professionals. Workshop, June 23-26, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Stress Management

Teaching Stress Management and Relaxation Skills

For: Interested health professionals. Workshop, June 2-6, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Hospital Administration

Marketing Strategies: A Diagnostic and Prescriptive Analysis for Corporate/Employee Services, Commercial, and Public/Private Wellness Programs

For: Hospital administrators, interested health professionals and marketing/advertising professionals. Workshop, June 16-19, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Pediatrics

Annual Update in Pediatics

For: Pediatricians, family practitioners. Workshop, June 6-7, St. Louis, MO. **Sponsors:** St. Louis University School of Medicine, 1402 South Grand Blvd., St. Louis, MO 63104 and Cardinal Glennon Children's Hospital. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed: 10 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Trauma

Advanced Cardiac Life Support Provider Course

For: Physicians and allied health professionals. Workshop, June 28-30, St. Louis, MO. **Sponsors:** St. Louis University School of Medicine, 1402 South Grand Blvd., St. Louis, MO 63104 and St. Louis Chapter of the American Heart Association. **Fee:** $150. **Reg. Limit:** 45. **Credit:** Category 1: 20 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Family Medicine/Orthopedics/Physical Medicine

Clinical Home Care in the 1980's: Economics, Implementation, and Ethical Issues

For: Interested health professionals. Conference, June 26-27, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705; Department of Medicine, School of Medicine, University of Wisconsin; and University of Wisconsin Hospitals and Clinics. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 14 hours; ADA: 14 hours; AAFP: 14 hours; AOA Category 2-D: 14 hours; and Univ. of Wisconsin CEUs: 14 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Emergency Medicine

Selected problems in Emergency Medicine

For: Practicing physicians. Symposium, June 21, Washington University Medical Center, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. Limit:** 100. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; and AOA: 6 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Internal Medicine/Oncology

Lymphomas: Diagnosis and Management

For: Practicing physicians. Symposium, June 19, Jewish Hospital at Washington University Med. Center, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Reg. Limit:** 200. **Credit:** Category 1: 4 hours; AAFP prescribed: 4 hours; and AOA: 4 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Obstetrics and Gynecology

Illinois Medical Schools OB/GYN Review Course

For: Obstetricians and gynecologists. Course, June 16-23. **Sponsors:** Medical Schools of Illinois, c/o The University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $550. **Reg. Limit:** None. **Credit:** Category 1: 37 hours; ACOG: 37 cognates. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

For: Obstetricians and gynecologists. Course, June 12-14, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 90. **Credit:** Category 1: 21 hours; Other: 19 Cognates Formal Learning by ACOG. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois (800) 621-4651.

Family Medicine

Specialty Review in Family Medicine

For: General and family practitioners. Lecture, June 9-20, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $810. **Reg. Limit:** 90. **Credit:** Category 1: 102 hours; AAFP Prescribed: 96 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois (800) 621-4651.

Critical Care Medicine

Critical Care Medicine: A Review of Current Practice

For: Critical care physicians, surgeons, primary care physicians, and anesthesiologists. Lecture, June 23-28, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $680. **Reg. Limit:** None. **Credit:** Category 1: 49 hours; PREP: 49 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois: (800) 621-4651.

Orthopedics

Specialty Review in Orthopedic Surgery

For: Orthopedic surgeons. Lecture, June 22-28, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $730. **Reg. Limit:** 90. **Credit:** Category 1: 66 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois (800) 621-4649; outside Illinois: (800) 621-4651.

Internal Medicine/Oncology
Lymphomas: Diagnosis and Management
For: Practicing physicians. Symposium, June 19, Jewish Hospital at Washington University. **Sponsor:** Washington University School of Medicine, Box 8064, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Reg. Limit:** 200. **Credit:** Category 1: 4 hours; AAFP Prescribed: 4 hours; and AOA: 4 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

JULY

Cardiology
Cardiac Rehabilitation
For: Interested health professionals. Workshop, July 21-25, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Stress Management
Teaching Stress Management and Relaxation Skills
For: Interested health professionals. Workshop, July 14-18, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed; 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Pulmonary/Cardiology
Pulmonary Circulation in Health and Disease
For: Physicians. Conference, July 8-11, Madison, WI. **Sponsors:** University of Wisconsin-Madison, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Department of Anesthesiology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 26 hours; Other: University of Wisconsin CEU's: 26 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Diagnostic Testing
Physicians' Office Testing Exposition
For: Physicians, lab technicians, etc. Exhibit/Classroom, July 15-17, 9:00 a.m.-5:00 p.m., McCormick Place, Chicago. **Sponsor:** American Association for Clinical Chemistry, 1725 K Street, NW, Suite 1010, Washington, DC 20006. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Camille Smith. **Phone:** (800) 892-1400.

SEPTEMBER

Otolaryngology
Contemporary Head and Neck Reconstructive Surgery
For: Otolaryngologists. Workshop, September 24-27, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 60. **Credit:** Category 1: (hours to be determined). **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Nephrology/OB-Gyn/Family Medicine
Renal Function and Disease in Pregnancy
For: Nephrologists, obstetricians, and family practitioners. Symposium, September 18-20, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the National Kidney Foundation. **Fee:** $145. **Reg. Limit:** None. **Credit:** Category 1: 14 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Neonatology
Perinatal Care: Current Issues for the Primary Care Provider
For: Family practitioners, obstetricians and pediatricians. Seminar, September 11, Jumer's Castle Lodge, Urbana, IL. **Sponsors:** Carle Clinic Association, Educational Services, 611 W. Park Street, Urbana, IL 61801 and the University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $5. **Reg. Deadline:** 9/4/86. **Reg. Limit:** None. **Credit:** Category 1: 3.5 hours; AAFP Prescribed: 3.5 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3108.

Dermatology/Family Medicine/Geriatrics
National Symposium on the Prevention and Treatment of Pressure Ulcers
For: Dermatologists, family practitioners, and geriatrics specialists. Symposium, September 23-25, Chicago, IL. **Sponsors:** The University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the Chicago Department of Health. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Internal Medicine/Family Practice
Office Treatment of Hypertension
For: Internists, family practitioners, cardiologists, and general practitioners. Conference, September 24, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CMF, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 4 hours; AAFP Prescribed: 4 hours; and AOA: 4 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Psychiatry
Workshops for various specialties
For: Psychiatrists, anesthesiologists, family physicians, allergists, pediatricians. September 23-26, Chicago, IL. **Sponsors:** Society for Clinical and Experimental Hypnosis, 128-A Kings Park Drive, Liverpool, NY 13090; Department of Psychiatry and Department of Behavioral Sciences, University of Chicago; Department of Psychiatry, Michael Reese Hospital; Anesthesia Department, Northwestern University Medical School and Department of Psychology, University of Illinois at Chicago. **Fee:** $120-160 residents; $270-395 members; $340-480 non-members. **Credit:** Category 1: 30 hours; AAFP Elective: 30 hours; ADA: 30 hours; American Psychological Association: 30 hours. **Contact:** Marion Kenn. **Phone:** (315) 652-7299.

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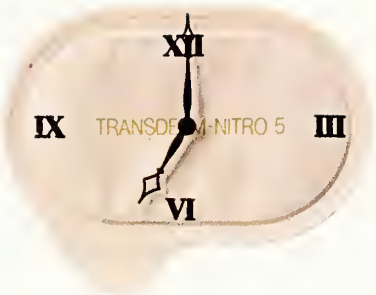
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All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information on the following page.)

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Transderm-Nitro®
(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26)
			*100 Systems (NDC 0083-2025-30)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26)
			*100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
			*100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)
			*100 Systems (NDC 0083-2115-30)

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C I B A

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:

Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

CARBONDALE:

Multi-specialty group needs the following physicians: Otolaryngologist, Ophthalmologist, Neurologist and OB/GYN physician. Contact Wayne Given, 2601 West Main, Carbondale 62901. (6)

FAIRFIELD:

Family oriented Southern Illinois community with 50 bed, full service hospital recently undergoing extensive renovation seeks board certified and residency trained family practitioner to join an established young practitioner as an associate in a busy practice. Must be qualified in, and enjoy obstetrics, as this is a major portion of the practice. A fully equipped clinic with x-ray and lab facilities is available. The service area of this community is 25,000 and there are presently only 5 full time physicians in the area. Guaranteed salary with incentive. This is an excellent opportunity for a physician who wishes to establish a practice quickly and to be financially comfortable in a small community which is an excellent place for raising children. Send CV to Michael A. Blood, M.D., Fairfield Memorial Hospital, Fairfield 62837, or call 618-673-2135. (6)

GRAYVILLE:

On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:

Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

ABSTRACTS OF ACTIONS

April 3-5, 1986

Westin O'Hare Hotel

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Tort Reform Activity

The Attorney General's response to the plaintiff's brief in the suit challenging the malpractice reform legislation was filed on March 17. It urged reversal of Judge Joseph Wosik's decision holding five elements of the ISMS malpractice reform legislation unconstitutional. ISMS legal counsel reported on the March 27th hearing by the Supreme Court in Springfield. The Supreme Court ruling on this is awaited.

The Illinois Coalition on the Insurance Crisis (ICIC) held a meeting on March 19, 1986, to discuss legislation they plan to introduce. It was agreed at that time to add a $300,000 cap on non-economic losses to a package previously approved.

Governor Thompson's staff met with leaders of the insurance industry, House Republican Leader Lee Daniels and Senate Republican Leader Pate Philip on March 14. The Governor's office indicated that this meeting was extremely successful. Representatives of the insurance industry understood the concerns of the political leaders in attendance that some commitment must be made to give Illinois special consideration if appropriate tort reform legislation is passed.

Directors and Officers Liability Insurance

The Board approved a proposal from a syndicate of Lloyds of London and other insurance companies for $1 million Directors and Officers Liability Insurance coverage at a $39,000 annual premium. The previous policy had a $5 million coverage. ISMS will acquire a reporting endorsement for the previous coverage. The new policy will be an annual policy for the Society, Insurance Services and the Exchange, and is designed to cover the Trustees, Directors, Governors and Officers of the three entities against wrongful acts.

Statement on CME

The Board approved a statement outlining a philosophy for Continuing Medical Education. It cites the means for physicians to achieve mandated CME, consonant with the new law, rather than the specific requirements mandated in the old law. The Board directed that the proposal be forwarded to the Illinois Medical Practice Examining Committee for consideration.

HCFA Proposed Regulations

The Board ratified the chairman's action forwarding ISMS comments to the AMA on proposed rule 42 CFR Part 405, Subpart E. The Health Care Financing Administration proposed to authorize the Secretary of HHS to establish "cost effective utilization rates and national charge levels for particular services rendered to the Medicare program." This would give HCFA authority to supercede the current system of setting a reasonable charge if HCFA believed that the resultant charge was not reasonable.

Task Force on Medical Discipline

The Board endorsed a: (1) Letter to Governor Thompson regarding nominations for the Medical Coordinator position in the Department of Registration and Education; and (2) Draft report to the Governor from the Task Force on Medical Discipline.

Other Actions

In addressing various other issues, the Board:

- Accepted the 1985 Audited Financial Statement; March 17, 1986, IMPAC Collection Data; March 17, 1986, Dues Payment Report; and Requests for Changes in Membership Status.
- Referred a request from Crescent County Foundation for Medical Care, regarding a PRO Appeals Committee, to the Executive Committee.
- Accepted with reluctance the resignations of Dr. Robert P. Johnson, trustee Fifth District and Dr. Eugene P. Johnson, trustee Eighth District.
- Adopted positions recommended by the Governmental Affairs Council on a list of primary bills pending in the General Assembly.
- Reaffirmed a proposal on Due Process Rules adopted by the Board of Trustees at its June, 1985, meeting, for transmittal to the Hospital Licensing Board.
- Approved a late resolution for introduction to the 1986 House of Delegates modifying an existing policy entitled, "Physician Recruitment Service."
- Approved a resolution for introduction to the 1986 House of Delegates entitled, "Medicare Fair Hearing Process."
- Elected Dr. Alfred J. Kiessel, Decatur, as chairman.
- Nominated Drs. Phillip Boren, Alfred Clementi, Robert Hamilton, Jerry Ingalls, Clifton Reeder and Warren Tuttle, for the ISMIS Board of Directors.

- Appointed Alexander R. Lerner as proxy for the shareholder, Illinois State Medical Society, at the annual meeting of ISMIS May 7, 1986, to cast the proxy vote for Directors of ISMIS.

Nominations

Acting on recommendations of the Councils and Executive Committee, the Board:

- Nominated Dr. Eugene P. Johnson, Casey, for appointment to the Task Force on Long-term Health Care Insurance.
- Ratified the appointment of Drs. Donald F. Pochyly, chairman, Ernesto B. Eusebio and Julius S. Newman, members, CME Accreditation Committee.

Other Matters

The Board also heard an informational report on HR 3128, the Consolidated Omnibus Budget Reconciliation Act (COBRA). HR 3128 contains several provisions which impact upon Part B Medicare policies, including the physician fee freeze. It had been approved by Congress and forwarded to the President for signature. HR 3128 had not been signed into law, but it was anticipated that the President will sign this in the near future.

The Executive Administrator introduced Mrs. Sharon Bell, Springfield, the new Executive Administrator of the Sangamon County Medical Society.

Mr. Saul Morse, ISMS legal counsel, discussed two recent decisions regarding mandated limits of coverage, and the issue of the contractual nature of medical staff bylaws.

Awards

Officers and trustees completing terms of office were presented plaques in appreciation of their service.

Certificates of appreciation were presented to ISMS staff members Elizabeth Duffy for 20 years of service and Mariann Stephens, Henry Nussbaum and John Patton, 10 years.

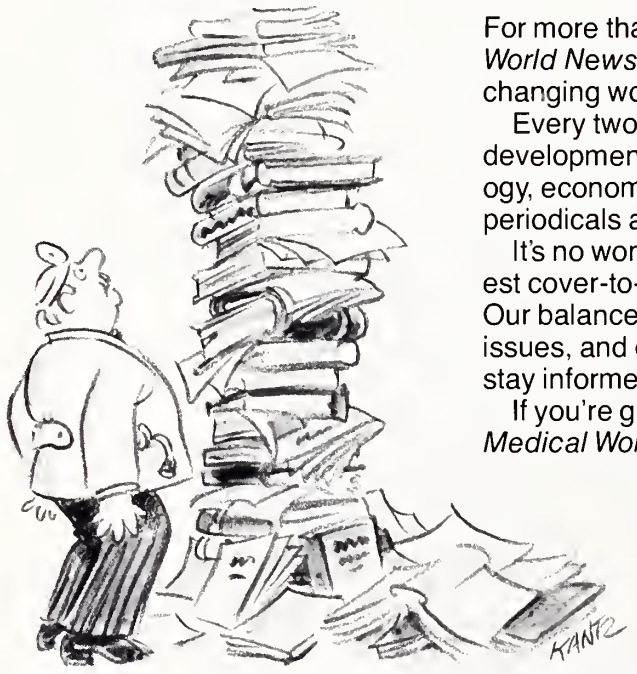
Informational Reports

Informational reports were presented on Medicaid Fraud and Abuse Legislation, PLI Update, Locality Rule, Illinois Health Care Cost Containment Council Recommendations on Certificate of Need, and Medicaid Budget. Informational Reports were also presented by the Task Force on Financial Aid to Medical Students, Committee on CME Accreditation, Council on Public Relations and Membership Services, ISMIS, ISMIE, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section, Auxiliary, IMPAC, Speaker, Vice Speaker and the Chairman of the AMA Delegation.

Next Meeting

The next Board of Trustees meeting was set for June 21-22, 1986, at ISMS Headquarters. ◀

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OBITUARIES

****Allen, Glen I.,** Peoria, died January 1, 1986 at the age of 79. Dr. Allen was a 1931 graduate of Northwestern University Medical School, Chicago.

Armbruster, Francis J., Chicago Heights, died March 26, 1986 at the age of 77. Dr. Armbruster was a 1935 graduate of the University of Health Sciences/Chicago Medical School.

***Bartels, John F.,** Dallas, Texas, died March 8, 1986 at the age of 71. Dr. Bartels was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

Brennan, Francis J., Utica, died February 22, 1986 at the age of 70. Dr. Brennan was a 1942 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Brooks, Clyde M.,** Clearwater, Florida, (formerly of Carbondale) died February 13, 1986 at the age of 85. Dr. Brooks was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

Czajkowskyj, Theodor, Danville, died March 3, 1986 at the age of 66. Dr. Czajkowskyj was a 1951 graduate of the Medizinische Fakultat der Universitat Erlangen, Erlangen, Bayern, Germany.

***Donaldson, Lilian,** Chicago, died March 15, 1986 at the age of 78. Dr. Donaldson was a 1940 graduate of the University of Chicago Pritzker School of Medicine.

****Fink, Philmour,** Chicago, died March 15, 1986 at the age of 79. Dr. Fink was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

****Harter, Joseph A.,** Sherman Oaks, California, died March 20, 1986 at the age of 86. Dr. Harter was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

***Lerner, Harry A.,** Oak Park, died March 1, 1986 at the age of 76. Dr. Lerner was a 1937 graduate of the Medizinische Fakultat der Universitat Bern, Bern, Switzerland.

****Rarick, Alden J.,** Danville, died March 9, 1986 at the age of 79. Dr. Rarick was a 1931 graduate of the Indiana University School of Medicine, Indianapolis.

***Rosanova, Albert R., Sr.,** Palatine, died April 7, 1986 at the age of 72. Dr. Rosanova was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

****Rush, Paul W.,** San Juan Capistrano, California (formerly of Summit), died February 23, 1986 at the age of 92. Dr. Rush was a 1923 graduate of the University of Illinois College of Medicine, Chicago.

***Textor, Charles S.,** Wilmette, died March 10, 1986 at the age of 73. Dr. Textor was a 1936 graduate of the University of Pittsburgh School of Medicine, Pittsburgh.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Burtis E. Montgomery, M.D. ISMS Past President and Former Board Chairman

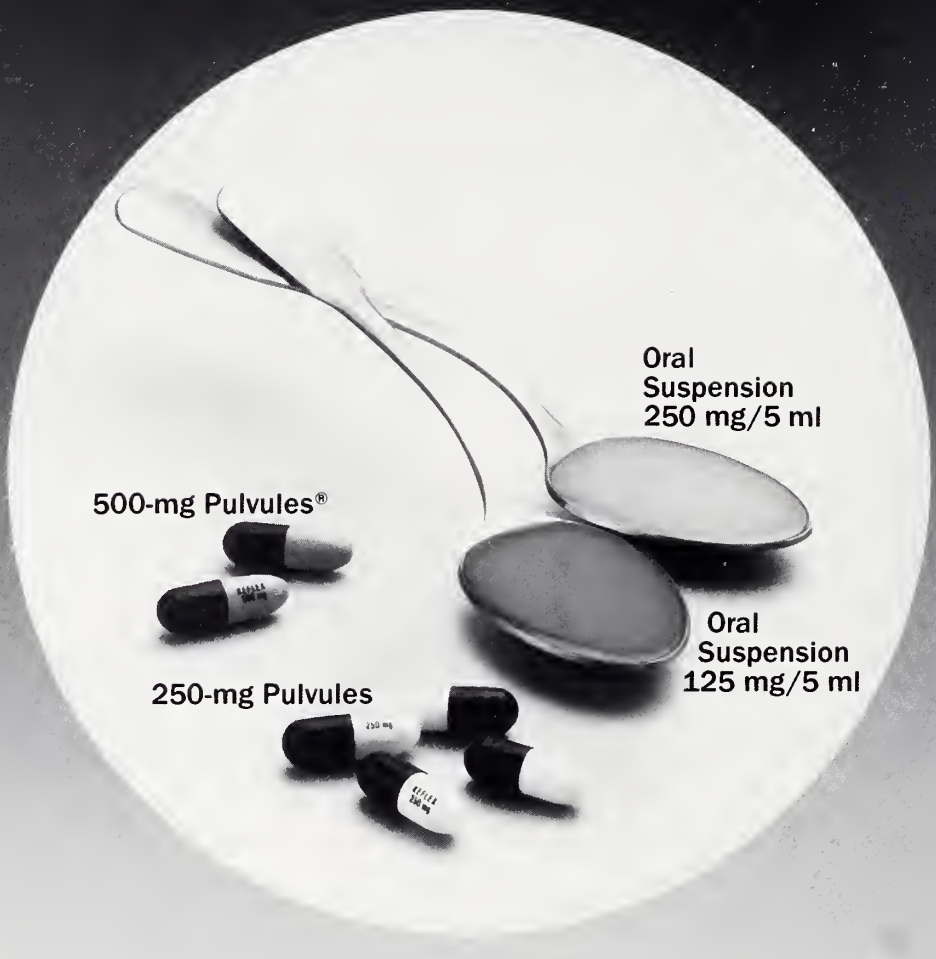
Burtis E. Montgomery, M.D., an ISMS past president and former chairman of the ISMS Board of Trustees, died April 14, 1986, at the age of 87.

A 1933 graduate of the University of Illinois College of Medicine who specialized in internal medicine, Dr. Montgomery served the Society as a trustee for 13 years, beginning in 1951. The 1965-66 president of ISMS, he also served as chairman of the ISMS Board of Trustees, 1957-60.

In 1966, Dr. Montgomery achieved national recognition when he was elected a trustee of the American Medical Association, a post which he held until 1970.

A native of Harrisburg, Dr. Montgomery was a member of the Saline-Pope-Hardin Medical Society. He moved to Spartanburg, South Carolina, upon retirement.

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Indications and Complications

Endoscopic Papillotomy

By Michael Goldberg, M.D., and Thomas J. Layden, M.D./Chicago

This communication summarizes results of endoscopic papillotomy in 35 patients with common bile duct stones or papillary stenosis. The reported indications, results, and complications are reviewed.

Cholecystectomy, with or without common bile duct exploration, is one of the most frequent surgeries performed in this country. This surgery is well tolerated in healthy patients. However, in patients with recurrent or retained common bile duct stones, bile duct exploration carries a mortality rate of 2%-5%. In patients 65 and older, postoperative mortality rates of 9%-18% have been reported.[1-3] With the development of endoscopic retrograde cholangiopancreatography (ERCP), several new techniques may be used to deal with complex biliary tract problems. Incision of Oddi's sphincter, endoscopic papillotomy (sphincterotomy), is being performed more frequently in patients with recurrent common bile duct stones and/or papillary stenosis.[3-8] It is now considered a relatively safe non-surgical alternative to bile duct surgery in patients with common bile duct stones.[3-8] The purpose of this paper is to describe our experience with endoscopic sphincterotomy and to review the indications, short and long term results, and potential complications of this procedure.

Papillotomy Methods

Patients with suspected biliary tract disease are taken to a radiologic suite and carefully sedated with diazepam and meperidine hydrochloride. A side-viewing endoscope is passed into the duodenum to identify the ampulla of Vater, which is catheterized with a #16-sized cannula. The common bile duct and pancreatic duct are visualized by injecting contrast dye. If a remedial lesion is seen, a papillotome is introduced and positioned 1-2 cm within the ampulla of Vater. (Figure 1) Wire is then tensed on the end of the papillotome and an electrosurgical current is applied. This cuts the common wall between the duodenum and common bile duct. The average length of the cut is 1.5cm. If stones are present, a balloon catheter or a catheter with a wire basket may be inserted through the incision to extract them. (Figure 2) It is sometimes best not to attempt extraction on the same day as the papillotomy. Stones will either pass spontaneously or can be extracted

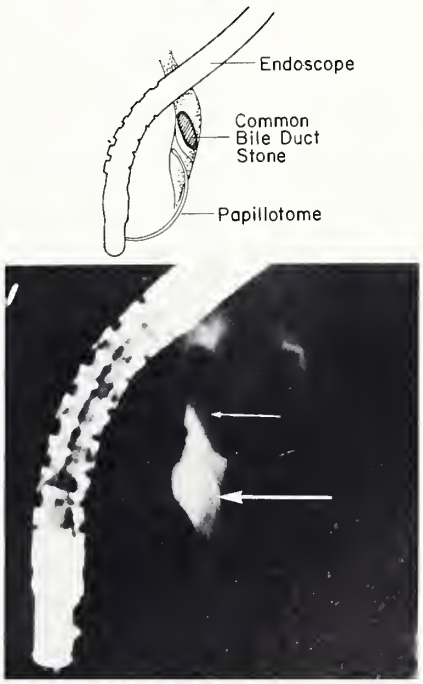


Figure 1.
As seen in the lower portion of the figure, a papillotome (large white arrow) is inserted into the common bile duct and a large gallstone measuring 1.2 × 2.0cm (small arrow) is seen following contrast injection. A diagram explaining this procedure is included.

at a later setting. If a sphincterotomy cannot be performed for technical reasons, a pre-cut or a small cut is made in the papilla and a sphincterotomy re-attempted approximately one week later.

Results

There were 35 patients in this study with an average age of 66. Twenty-two patients were female and 13 were male. Seventeen had significant coronary artery disease with a past history of myocardial infarction. Four patients had diabetes mellitus, four had a history of cerebrovascular disease, one had chronic obstructive pulmonary disease, and one had lung cancer. Only 12 patients were free of significant medical problems.

Twenty-four of the 35 patients had a previous cholecystectomy, while 11 had intact gallbladders. Five of the 24 patients with previous cholecystectomy were in the immediate post-operative period and retained stones were noted in the common bile duct by T-tube cholangiography. Repeated attempts to extract the stones through the T-tube had failed.

Nineteen of the 24 patients presented with one or more of the following problems: obstructive jaundice, pancreatitis, cholangitis or biliary colic. The mean duration between cholecystectomy and return of these patients was 4.5 years (range: one to ten years). In 11 of the 19 patients, one to three stones were identified in the common bile duct at ERCP. (Figure 1, 2) In eight patients there was either manometric or clinical evidence of papillary stenosis or dysfunction. A papillotomy was attempted in all 24 patients and was completed in 22 patients (91% success). Fifteen of 16 patients with stones and no gallbladder underwent successful papillotomy, as did seven of eight patients with papillary stenosis. Fifteen of the 16 patients with stones had them removed. A papillotomy was accomplished in seven of the eight patients with papillary stenosis with improvement in jaundice and abdominal pain. In one patient, however, pain returned after a short follow up.

Eleven patients with intact gallbladders presented with jaundice, pancreatitis, or ascending cholangitis. Stones were noted in the common bile duct and/or gallbladder. (Figure 3) Attending physicians did not consider these patients to be good emergency surgical candidates, so a papillotomy was attempted in each case. In nine of the eleven patients, papillotomy was successful and extraction of common bile duct stones was accomplished in seven. One patient who was initially considered a failure had passed half of her common bile duct stones by the time of surgery several days later.

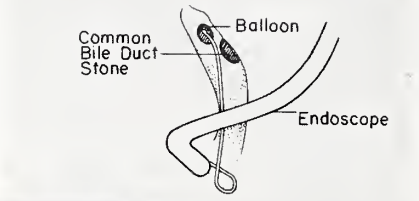




Figure 2.
The common bile duct containing a gallstone (white arrow) is visualized at ERCP. A balloon catheter (black and white arrow) is above the stone. A diagram is included.



Figure 3.
The common bile duct and gallbladder are visualized in a patient who presented with abdominal pain and pancreatitis. Stones are noted in the gallbladder.

Complications

Four complications occurred in the 35 patients. One patient had a duodenal perforation which was treated with antibiotics and intravenous feeding and did not require surgical intervention. Two patients had a self-limited episode of mild pancreatitis. One patient with an intact gallbladder developed severe pancreatitis and died two months later after three surgeries for a pancreatic abscess.

Discussion

Accepted indications for endoscopic papillotomy include: (1) recurrent or retained common bile duct stones; (2) papillary stenosis and (3) common bile duct stones in patients who have an intact gallbladder and are deemed to be poor surgical risks. The success rate in performing a sphincterotomy with extraction of the common bile duct stones ranges from 55% to 85%[3-8] which is similar to our success rate.

A three to eight year follow-up study of 248 patients who had had sphincterotomy for common bile duct stones was recently published.[6] Results revealed that 87% reported sustained relief of symptoms. In that study, 70 patients consented to repeat ERCP and stenosis of the sphincterotomy was noted only in 5% of patients. This short and long term success rate compares quite favorably to results reported following common bile duct exploration with or without sphincterotomy.[1-2] Endoscopic papillotomy requires only one or two days of hospitalization, and if an experienced endoscopist is available, endoscopic papillotomy is the procedure of choice for retained or recurrent common bile duct stones.

Endoscopic sphincterotomy has been used more frequently in patients with choledocholithiasis and an intact gallbladder, particularly when the patient has significant concurrent medical problems. In our small series none of the

patients with a successful stone extraction have required cholecystectomy, although follow-up has been brief. One investigator reported that only 25 of 100 patients required an interval cholecystectomy three to eight years after a sphincterotomy.[6] It is believed that endoscopic sphincterotomy will not replace cholecystectomy, but in select patients with significant medical problems, it may serve as both a short and long term means to deal with cholelithiasis.

Papillary stenosis resulting either from choledocholithiasis or a primary disorder has been increasingly recognized with the greater use of ERCP. As this disorder can be overdiagnosed, the following criteria should be met: recurrent upper abdominal pain; dilated common bile duct (greater than 1.2-1.5cm) that does not spontaneously drain dye within 45 minutes; and biochemical evidence of intermittent obstruction of the biliary and/or pancreatic system. Manometric pressure measurements of the Oddi's sphincter during ERCP may eventually help to confirm this diagnosis.

In our small series, six of the seven patients with papillary stenosis were asymptomatic following a successful papillotomy. In one series, 32 of 37 patients had complete or marked relief of symptoms following sphincterotomy.[6] However, further carefully conducted studies are needed to verify the usefulness of sphincterotomy in this condition.

The reported mortality rate of endoscopic papillotomy varies between 0.6% and 1.8%.[3-8] Complications which occur in 5%-10% of procedures include: pancreatitis, duodenal wall perforation, duodenal hemorrhage, and biliary tract sepsis. Endoscopic papillotomy should not be performed in patients with a long distal common bile duct stricture, severe coagulopathy or acute pancreatitis. It should also be avoided when the papilla of Vater is located within a duodenal diverticulum. As exploratory surgery may be required in 2%-5% of patients, patients should be carefully monitored for 24-36 hours.[3-8] Reduction in complications and mortality comes with experience; since papillotomy is a technically difficult procedure, it should not be approached by the inexperienced endoscopist. ◀

References

1. Hinderleider, C., Saperstein, L.: "A Review of 814 Cases of Biliary Tract Surgery from 1951-1977," *Mt. Sinai* 46:243-6, 1979.
2. McSherry, C.K., Glenn, F.: "The Incidence and Causes of Death Following Surgery for Non-Malignant Biliary Tract Disease," *Ann Surg.* 191:271-5, 1980.
3. Seigel, J.: "Endoscopic Papillotomy in the Treatment of Biliary Tract Disease," *Dig. Dis and Sci.* 26:1057-1064, 1981.
4. Cotton, P.B.: "Non-Operative Removal of Bile Duct Stones by Duodenoscope Sphincterotomy," *Br. J. Surg.* 67:1-5, 1980.
5. Cotton, P.B., Vallon A.G.: "British Experience with Duodenoscope Sphincterotomy for Removal of Bile Duct Stones," *Br. J. Surg.* 68:373-75, 1981.
6. Rosch, W., Riemann, J.F., Lax, G., and Linder, H.G.: "Long Term Follow Up after Radioscopic Sphincterotomy," *Endoscopy* 13:152-153, 1981.
7. Nakajima, M., Kiza, M., Akasuha, Y.: "Five Years Experience of Radioscope Sphincterotomy in Japan," *Endoscopy* 11:138-141, 1979.
8. Safrany, L.: "Duodenoscopic Sphincterotomy and Gallstone Removal," *Gastro* 72:338-343, 1977.
9. Wilson, I.D., *et al.*: "Choledocholithiasis," *Gastro* 75:120-128, 1978.

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Cardiac Myxoma

By James J. Boblick, M.D., Joel A. Schneider, M.D., Naeem Khan, M.D., Habibur Rahman, M.D. and George J. Taylor, M.D./Springfield & Centralia

Atrial myxoma is the most common tumor of the heart. Before echocardiography, myxoma was rarely diagnosed pre-mortem.[1-4] A variety of presenting symptoms and a paucity of physical findings make clinical diagnosis difficult. Over the last year, four of our patients had surgical resection of cardiac myxoma, and each exhibited different clinical manifestations. These four patients were seen in a 12 month period, during which 680 patients had open heart surgery.

The first case was a 35-year old black woman with a history of hypertension who presented with dyspnea on exertion and at rest, paroxysmal nocturnal dyspnea and orthopnea. There was no peripheral edema. She had lost 40 pounds over the previous year, and had experienced an episode of fever attributed to pneumonia. Two years prior to this admission, she had developed similar, although milder, symptoms and a cardiac evaluation had been performed. Cardiac catheterization showed normal left ventricular function and size and normal coronary arteries; an echocardiogram was not done. At the present admission a loud, high pitched and resonant diastolic sound was heard after the second heart sound, probably a "tumor plop." Laboratory examination showed a hypochromic, microcytic anemia, and erythrocyte sedimentation rate of 55mm/hr (Westergren method). The echocardiogram demonstrated a left atrial mass large enough to obliterate most of the left atrial cavity. The mass protruded through the mitral annulus during diastole. (Figure 1) At surgery, a left atrial myxoma measuring 6×6×4.5cm. was removed. Symptoms of left heart congestion did not recur after surgery.

Case Two

This 70-year-old white woman reported paroxysmal atrial tachycardia and fibrillation, chest pain and weakness for four months. Physical examination and laboratory studies were normal. Electrocardiogram showed normal sinus rhythm with incomplete right bundle branch block and frequent atrial ectopics. Echocardiogram showed a right atrial mass. At surgery, a right atrial myxoma measuring 5×3cm. in diameter was removed. Intermittent atrial tachy-arrhythmias are presently controlled with beta blockers.

Case Three

This 53-year-old white woman reported syncope for less than one minute, followed by left arm and leg weakness for two hours. There was mild dysarthria during that time. At hospital admission, she had complete recovery of function and normal neurological examination. Non-invasive carotid studies were normal, and no cardiac arrhythmias were observed on telemetry. Other laboratory work was normal with the exception of an erthrocyte sedimentation rate of 40mm/hr. Echocardiogram showed a left atrial mass. Surgery was performed and a left atrial myxoma, 3cm. in diameter, was removed. Recovery was uneventful and the patient has remained asymptomatic.

Case Four

This 51-year-old white man had a two-week history of weakness, nausea, vomiting and diarrhea. Abdominal examination was normal, and no specific etiology was found for these symptoms. On examination he was found to have a pericardial friction rub. Laboratory studies showed a platelet count of 28,000 with normal hemoglobin and erythrocyte sedimentation rate. Because of the rub, an echocardiogram was performed, which demonstrated a right ventricular mass. At surgery, this mass was found to weigh 148gm. Symptoms did not recur after surgery and the platelet count returned to normal.

Discussion

Atrial myxoma is the most common primary tumor of the heart with an autopsy incidence of 0.03%. Buckley and Hutchins described only 24 cases of myxoma in a 50

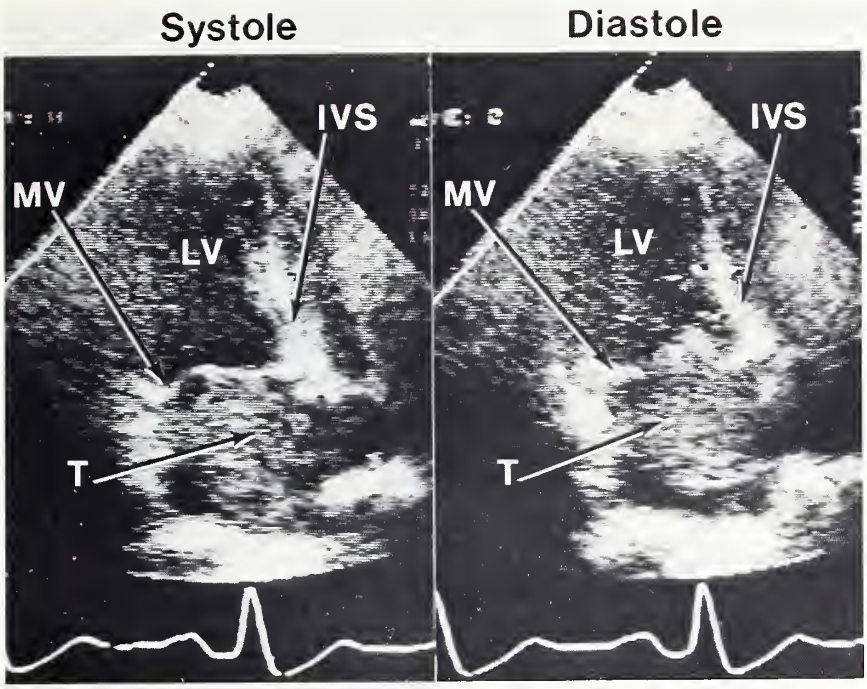


Figure 1

year review at the Johns Hopkins Hospital.[1] In contrast, our four patients were treated within a 12 month period, during which time 680 patients had open heart surgery. This suggests a higher incidence (0.6%) than previously reported, which may be due to increased recognition of atrial tumors with improved diagnostic capability. Three of our four patients had the initial echocardiogram in their community hospitals and were referred for treatment with diagnosis complete. This demonstrates the importance of echocardiography in a community hospital setting rather than solely as a diagnostic tool of the tertiary referral center.

The diagnosis of atrial myxoma is readily made, as the echocardiogram is sensitive and echocardiographic features of myxoma are specific. On the other hand, clinical presentation is often vague.[2-3] Each of our four patients had different symptoms at presentation. Case one had symptoms suggesting mitral stenosis or heart failure, case two atrial arrhythmias, case three peripheral embolization and case four constitutional symptoms with thrombocytopenia and pericardial friction rub.

Clinical presentation may depend on the location of the tumor.[4] Left-sided tumors can mimic mitral valvular disease or cause peripheral arterial embolization. Syncope may result from arrhythmia or obstruction of the mitral valve. Right heart tumors may mimic cor pulmonale or cause pulmonary emboli. Constitutional features of myxoma are common, and include fever, malaise, weight loss and anemia. Many patients have an elevated erythrocyte sedimentation rate; this was seen in three of our four patients. Tumor degeneration has been suggested as a cause of constitutional symptoms.

Myxoma can masquerade as a variety of conditions. It is apparent that an echocardiogram is an appropriate early diagnostic technique for a number of these conditions. For others, atrial myxoma should be considered if initial studies fail to produce a diagnosis.

Cardiac myxoma is a benign tumor that can be resected with low risk of morbidity and mortality. Most symptoms can be expected to resolve postoperatively. ◀

References

1. Bulkley, B.N., Hutchins, G.M.: "Atrial Myxomas: A Fifty Year Review," *Am Heart J* 97:639, 1979.
2. Colucci, W.S., Braunwald, E., in Primary Tumors of The Heart, E. Braunwald, ed., 2nd Ed., Chapter 42, W.B. Saunders and Co., Philadelphia, 1983.
3. Nasser, W.K., Davis, R.H., Dilloin, J.C., Travel, M.E., Helmen, C.H., Geigenbaum, H., and Fisch, C.: "Atrial Myxoma: I. Clinical and Pathologic Features in Nine Cases. II. Phonocardiographic, Echocardiographic, Hemodynamic and Angiographic Features in Nine Cases." *Am Heart J* 83:694,810, 1972.
4. Prichard, R.W.: "Tumors of the Heart. Review of the Subject and Report of One Hundred and Fifty Cases," *Arch Pathol* 51:98, 1951.

Acknowledgment

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1986 Annual Meeting House of Delegates

The ISMS House of Delegates met at the Westin O'Hare Hotel in Rosemont, April 4-5, 1986, and took the following actions. The official minutes of the House are on file at the Headquarters Office of the Illinois State Medical Society.

Unfinished Business

Substitute 7 (A-85) Adopted
(BOT Report B)—Capitated Health System Insolvency Insurance
Introduced by Jere E. Freidheim, M.D., Chairman, Cook County Delegation

Directed that the Illinois State Medical Society work with the Department of Insurance to ensure that adequate rules and regulations are promulgated under HB 1663 to assure continuity of care for patients enrolled in capitated health systems for the duration of the capitated contract period.

21 (A-85) Not Adopted
(BOT Report C)—Directors and Officers Insurance
Introduced by Theodore M. Kanellakes, M.D., for the Will-Grundy County Medical Society

Defeated this resolution which called upon ISMS to provide County Medical Societies the opportunity of securing Directors and Officers Insurance by means of a rider attached to the Illinois State Medical Society's existing policy.

Substitute 24 (A-85) Adopted
(BOT Report D)—Psychiatric Care in State Hospitals
Introduced by Kishore J. Thampy, M.D.

Directed that: (1) the Illinois State Medical Society urge the Illinois Department of Mental Health and Developmental Disabilities to recruit more psychiatrists, and to require that patients be evaluated and treated by a psychiatrist on a regular basis; and (2) The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determining the delivery of that care. Each hospital or hospital system should establish and monitor its own standards, within the broad context of duly established regional standards.

25 (A-85) Not Adopted
(BOT Report E)—Nursing Home Residents
Introduced by Kishore J. Thampy, M.D.

Defeated this resolution which called upon ISMS to: (1) Introduce legislation in the State Assembly enabling the expenditure of State funds to subsidize the Federal Program; and (2) Introduce a similar resolution in the AMA House of Delegates to authorize additional federal payments to nursing home residents.

29 (A-85) Not Adopted
(BOT Report F)—Specified Frequency of Physician Visits to Nursing Home Patients
Introduced by Robert M. Reardon, M.D., for the McLean County Medical Society

Defeated this resolution which called upon ISMS to instruct the AMA Delegation to actively seek the elimination of the regulation in the Federal Register Volume 45, No. 136, July 14, 1980, Section 438.21 in the interest of cost containment.

Substitute 31 (A-85) Adopted
(BOT Report G)—Medicare and Its Effect on Resident Programs
Introduced by Charles Cattano, M.D., for the ISMS Resident Physicians Section

Directed that the ISMS Board of Trustees, through appropriate councils and committees, continue to study the effects of Medicare changes on reimbursement of patient care and funding grad-

uate medical education to include but not be limited to the following areas: (1) The number of resident training programs in Illinois; (2) The number of physicians in Illinois residencies; (3) The types of specialty and subspecialty programs; (4) The expenditures on graduate medical education; and (5) Resident salary.

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

4 (A-86) Adopted As Amended
Council on Affiliate Societies
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Directed that: (1) The ISMS bylaws be amended in Chapter IX, Section 2H, by deletion of this section creating the Council on Affiliate Societies; (2) Any references to the Council on Affiliate Societies be removed, should any appear in any other section of the bylaws or the policy manual; and (3) Chapter IV, Section 1, Paragraph 2, be amended as follows: " . . . and one representative from each recognized medical specialty society as approved by the Board of Trustees."

7 (A-86) Adopted
Insurance Committee
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Directed that the Committee on Insurance be established as a Committee of the Board of Trustees by deletion in the bylaws of Chapter IX, Section 5B, and transfer of this language to Bylaws Chapter IX, a new Section 8J.

9 (A-86) Adopted
Policy Statement on Freedom of Choice
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Freedom of Choice" as follows:

FREEDOM OF CHOICE
The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

24 (A-86) Not Adopted
Changes in Emeritus Requirements
Introduced by Albert W. Ray, Jr., M.D., for the Will-Grundy County Medical Society

Defeated this resolution which called upon ISMS to: (1) Lower the age requirement for Emeritus status to 65; (2) Alter the bylaws of the ISMS to reflect this change; and (3) Seek a corresponding change in the bylaws of the American Medical Association by means of a resolution to the AMA House of Delegates.

32 (A-86) Adopted
ISMS Policy Statement on "Physician Recruitment Service"
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Physician Recruitment Service" as follows:

PHYSICIAN RECRUITMENT SERVICE
The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors in training in Illinois and to those who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.

36 (A-86) Referred to Board for Study
Medical Staff Bylaws for Outpatient Surgi-Centers
Introduced by Harold L. Jensen, M.D., Chairman, Cook County Delegation

Referred to the Board of Trustees for study a proposal that ISMS seek legislative reform in the appropriate licensing act requiring all surgical centers to have medical staff bylaws; and that the medical staff bylaws be consistent with the due process guidelines as provided by the State of Illinois and U.S. Constitutions.

Reports
Filed for information the following reports:

Committee on Constitution and Bylaws, Judicial Panel and Policy Committee.

REFERENCE COMMITTEE A

3 (A-86) Not Adopted
Good Samaritan Act
Introduced by Harold L. Jensen, M.D., Chairman, Cook County Delegation

Defeated this resolution which called upon ISMS to seek amendment to the Good Samaritan Act to cover those physicians who would voluntarily provide care free of charge, but who are reluctant to do so because of the liability question.

5 (A-86) Adopted As Amended
Dues Structure
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Directed that: (1) A $20 increase in annual dues to the Illinois State Medical Society be adopted in 1987; and (2) The Board of Trustees withhold implementation, if, in the budgetary process for that year, it is determined that such an adjustment is not necessary.

16 (A-86) Referred to Board for Study

Honesty in Offering an HMO

Introduced by S. J. Schimel, M.D.

Referred to the Board of Trustees for study a proposal that ISMS cause legislation to be introduced in the General Assembly to mandate employers to give employees a choice between private insurance and an HMO, and to forbid employers to offer only HMO's and not private insurance policies.

18 (A-86) Referred to Board for Study

Reduced Dues for Physicians Leaving Training and Entering Practice

Introduced by William B. Frymark, M.D.

Referred to the Board of Trustees for study a proposal that ISMS: (1) Give serious consideration to reducing membership dues for physicians just out of training who are going into practice, to 25% dues for the first year; 50% for the second year; and 75% for the third year; and (2) Introduce a similar resolution to the House of Delegates of the American Medical Association for similar action.

Substitute 23 (A-86) Adopted

Statute of Limitations for Minors

Introduced by Silvana Y. Menendez, M.D., for the Hospital Medical Staff Section

Directed that the Society pursue legislation which would establish a reasonable statute of limitations for medical negligence lawsuits brought on behalf of minor plaintiffs.

30 (A-86) Referred to Board for Study

Ad Hoc Committee on the Young Physician

Introduced by Rockford G. Yapp, III, M.D., for the Resident Physicians Section

Referred to the Board of Trustees for study a proposal that ISMS establish an Ad Hoc Committee on the Young Physician to investigate the following: (1) Assess the changing needs of the young physician; (2) Means to increase membership in organized medicine; (3) Mechanisms to encourage active participation in organized medicine; and (4) The difficulties with the transition from resident to regular member.



The ISMS House of Delegates grapples with hard choices.

33 (A-86) Adopted As Amended

Minimum Liability Insurance as a Hospital Requirement for Medical Staff Privileges

Introduced by Carlos B. Lara, M.D., for the Pike County Medical Society

Directed that the Society: (1) Work together through its Board of Trustees with the Illinois Hospital Association to find a mutually beneficial solution to the problem of minimum liability insurance as a hospital requirement for medical staff privileges; and (2) Communicate this to its membership.

Reports

Filed for information the following reports:

President, President-Elect, First Vice-President, Second Vice-President, Secretary-Treasurer, 1985 Dues by County, Chairman Board of Trustees, Trustees, Executive Administrator, AMA Delegation, Illinois Society, American Association of Medical Assistants, Governmental Affairs Council, Medical-Legal Council, Committee on Insurance, Educational and Scientific Foundation, Auxiliary, Illinois State Medical Insurance Services, Inc.

REFERENCE COMMITTEE B

Substitute 2 (A-86) Adopted

Liability for Forced Hospital Patient Discharge

Introduced by Edwin Sinaiko, M.D., Delegate

Directed that the Society: (1) Communicate to its membership, and to the public, a physician's rights and responsibilities concerning patient discharge, stressing that a physician is under no obligation to discharge patients prematurely and that only a patient's physician is entitled to authorize discharge. Financial and other pressures must not be allowed to jeopardize the welfare of the patient; and (2) Act to oppose the pressures on physicians to inappropriately discharge patients and make the public aware of these pressures.

8 (A-86) Referred to Board for Study

Policy Statement on Governmentally-Supported Health Facilities

Introduced by Alfred J. Clementi, M.D, for the Board of Trustees

Referred to the Board of Trustees for study a proposal that ISMS delete the following policy statement on "Governmentally Supported Health Facilities": "ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine."

10 (A-86) Adopted

Public Aid Policy Statement

Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Public Aid" as follows:

PUBLIC AID

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multi-specialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multi-specialty care for Public Aid patients should be made available without extensive justification procedures.

12 (A-86) Adopted

Policy on Relationship with Third Party Payors

Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Relationship with Third Party Payors" as follows:

RELATIONSHIP WITH THIRD PARTY PAYORS

ISMS should provide appropriate guidance, education, and communications between the membership and third party payors.

25 (A-86) Adopted As Amended

Medicare Program Discrimination

Introduced by Michael C. Ferdinands, M.D., for the Rock Island County Medical Society

Directed that the Society: (1) Introduce a resolution to the American Medical Association urging it to use all appropriate means, including court action, if necessary, to end blatant discrimination against senior citizens and the medical profession under Medicare; and (2) Encourage the American Medical Association to counsel with senior citizens' organizations about discrimination which occurs under Medicare and educate the public to the fact that the costs of medical practice continue to rise while fees are frozen and the increased costs can only be covered by shifting them to other patients.



More than 300 medical society and auxiliary members participated in the Public Affairs Breakfast.

Substitute 26 (A-86) Adopted
Preventive Care for Medicaid Recipients
Introduced by Michael Davidson, M.D., Chairman, Resident Physicians Section

Directed that the Society urge IDPA to encourage Medicaid patients to establish a relationship with a physician of his/her own choice so that continuity of care is provided.

28 (A-86) Adopted
Medicare Fair Hearing Process
Introduced by Arthur R. Traugott, M.D.

Directed that the Society strongly urge the AMA to review the Medicare Hearing Process, its use of carrier employees as hearing officers and the lack of ability to appeal fair hearing determinations to the courts, and take appropriate measures to reverse these policies.

31 (A-86) Not Adopted
Exhaustion of Allocated Medicaid Days
Introduced by Rockford G. Yapp, III, M.D., for the Resident Physicians Section

Defeated this resolution which called upon the Society to oppose specific Illinois Medicaid policies which result in the: (1) Inappropriate transfer of inpatients solely on the basis of a hospital's exhaustion of its allocated Medicaid days; (2) Disruption of the continuity of care when an Illinois Medicaid patient cannot be admitted to a hospital where his attending physician has admitting privileges. Also called for teaching hospitals to be granted additional Illinois Medicaid days to preserve the quality of resident training.

34 (A-86) Adopted
Acceptance of Standard Claims Forms
Introduced by Harold L. Jensen, M.D., Chairman, Cook County Delegation

Directed that the Society: (1) Strongly encourage all HMOs, IPAs and other reimbursement systems existent now and in the future to utilize the already established and available standard health claims form; and (2) Introduce a similar resolution to the next meeting of the American Medical Association's House of Delegates.

Substitute 39 (A-86) Adopted
Collective Bargaining
Introduced by Jaime H. Cercone, M.D., Delegate, Fulton County Medical Society

Directed that the Society actively pursue the passage of legislation which would permit physicians to negotiate as a group, terms and conditions with respect to compensation and quality of care for the public of Illinois.

Reports
Filed for information the following reports:

Committee on Third Party Payment Processes, Council on Economics, Committee on Health Planning, Committee on Drugs and Therapeutics.

REFERENCE COMMITTEE C

6 (A-86) Adopted As Amended
ICCME
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Directed that the Society: (1) Dissolve the Illinois Council on Continuing Medical Education (ICCME) and that portion of dues designated for support of ICCME revert to ISMS for the support of education programs under the aegis of ISMS; (2) Maintain its status as an accrediting body and still retain the essential functions of ICCME, by incorporating these activities within other appropriate Society Councils, and continue to make available professional personnel and educational support to local CME programs as needed; and (3) Amend the ISMS policy manual by removing references to ICCME, particularly in the section entitled "Continuing Education," which would be amended as follows:

CONTINUING EDUCATION
The Illinois State Medical Society shall continue its strong support of voluntary continuing medical education in Illinois and the intra-state accreditation of quality CME programs. Continuing education is one of the basic functions of the Illinois State Medical Society, which is committed to scientific advancement, humanization of medicine, and development of cooperation and rapport with the public.
ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities
Physicians are encouraged to analyze their individual learning needs before registering for CME courses.
All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.
Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.

Substitute 13 (A-86) Adopted
Policy Statement on "Nurses—Shortage"
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Nurses—Shortage" as follows:

NURSES—SHORTAGE
The ISMS supports nursing education at all its levels.



Illinois Governor James R. Thompson: Physicians as vigorous advocates.

15 (A-86) Adopted
Medical Staff Privileges
Introduced by Luis E. Cespedes, M.D., Delegate, DuPage County Medical Society

Endorsed the principle that: (1) A physician's productivity at a single institution should not be considered a criterion for medical staff reappointment; (2) The House of Delegates of both the Illinois State Medical Society and the American Medical Association reaffirm their policies that a physician's medical staff privileges should be based on clinical competency and quality of care; and (3) This policy be communicated to all medical staffs.

19 (A-86) Not Adopted
Abortion Law
Introduced by Gail Herman, for the Medical Student Section

Defeated this resolution which called upon the Society to object to Section 15 (1) of the Illinois Medical Practice Act, Ill. Rev. Stat. ch. 111, para. 4433 (1) and the Ambulatory Surgical Treatment Center Act of Illinois, Ill. Rev. Stat., ch 111½, para. 157-8.1—157-8.16 in their form as of November 1, 1985, since they interfere with a woman's right to obtain, and a physician's right to perform, first and early second trimester abortions.

22 (A-86) Adopted
Risk Management
Introduced by Silvana Y. Menendez, M.D., for the Hospital Medical Staff Section

Directed that ISMS policy be that: (1) Hospital medical staffs recognize the legitimacy of hospital risk management programs to help protect the hospital, the medical staff and hospital personnel from unnecessary claims and lawsuits; (2) It is paramount that risk management activity not adversely affect the ability of a physician from exercising his legal and professional responsibilities to practice medicine and ensure quality care; and (3) The hospital medical staff be the primary resource which works with the hospital to establish those elements of risk management which directly affect patient medical care.

29 (A-86) Referred to Board for Study
Addressing the Health Insurance Needs of the Short-Term Unemployed and those Persons "Medically Uninsurable"
Introduced by Rockford G. Yapp, III, M.D., Resident Physicians Section

Referred to the Board of Trustees for study a proposal that: (1) The ISMS, in concurrence with the AMA, investigate the establishment of a state-wide program to provide health insurance for the short-term unemployed; and (2) Following such study, if indicated, the ISMS seek to enact legislation establishing a state risk-pooling program to ensure that adequate health insurance coverage is available at an affordable cost for those who would otherwise be unable to obtain such coverage because of medical considerations.

40 (A-86) Adopted As Amended
Peer Review
Introduced by Chester Danehower, M.D. for the Peoria Medical Society

Directed that the Society incorporate the following statement into the ISMS Policy Manual: "The Illinois State Medical Society is opposed to utilization review which is not conducted by one's peers. A 'peer' is a currently licensed physician, licensed to practice medicine in all its branches, who is experienced in the medical question under consideration and, whenever possible, whose primary practice is in the community involved. The Illinois State Medical Society is opposed to utilization review conducted entirely by telephone or similar communications, with no availablity of review by a physician in the region of the state, whose practice is in the same specialty, whether broad or narrow, as the item under review."

Reports

Filed for information the following reports:

Council on Medical Services, Council on Mental Health and Addiction, Council on Education and Manpower, Committee on Accreditation, Loss Prevention Committee, Publications Committee, Task Force on Financial Aid to Medical Students, Student Loan Fund, Committee on the Impaired Physician, Hospital Medical Staff Section, Resident Physician Section, Medical Student Section, ICCME, IDPH, IDMH/DD, DRE, DORS, DASA, DOA.

REFERENCE COMMITTEE D

1 (A-86) Referred to Board for Study

Corporal Punishment in Illinois Schools

Introduced by Eugene Loftin, M.D., for the Wayne County Medical Society

Referred to the Board of Trustees for study a proposal that the Society: (1) Oppose the use of corporal punishment or violence of any kind against students in Illinois schools; and (2) Through the appropriate committees, councils and other action groups, work to amend the Illinois School Code to eliminate corporal punishment or threat of corporal punishment as a form of discipline in Illinois schools.

11 (A-86) Adopted As Amended

Policy on Governmental Health Insurance Program

Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Health Insurance, Governmental Programs" as follows:

HEALTH INSURANCE, GOVERNMENTAL PROGRAMS

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental Health Insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental Health Insurance Programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured as long as the plan has a demonstrated physician-supported patient care management program in effect.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs for limited license practitioners without direct supervision and responsibility for patient care by a physician licensed to practice medicine in all its branches in Illinois.

14 (A-86) Referred to Board for Study

Application of Input-Output Economics to Health Care

Introduced by David A. Rothstein, M.D., Delegate

Referred to the Board of Trustees for study a proposal that ISMS: (1) Support the explication of the input-output approach and make the membership aware of this approach; (2) Lend support to efforts to apply the input-output approach to health care; and (3) Communicate this information to the AMA and introduce a similar resolution to the next meeting of the American Medical Association's House of Delegates.

17 (A-86) Adopted As Amended

Medical School Tobacco Stock Holdings

Introduced by Gail Herman, for the Medical Student Section



Members of the ISMS Fifty Year Club

Directed that the Society inform Illinois universities that while teaching the harmful effects of tobacco, they are encouraging a major health hazard by owning stock in tobacco companies.

20 (A)86) Not Adopted
Hand Gun Control
Introduced by Gail Herman, for the Medical Student Section

Defeated this resolution which asked that the Society call for a: (1) Statewide ban on the sale of handguns in Illinois; and (2) Freeze of all further registration of handguns in Illinois.

21 (A-86) Not Adopted
Warning Label on Sale of Chewing Tobacco
Introduced by Sadiq Mohyuddin, M.D., for the Madison County Medical Society

Defeated this resolution which called upon the Society to: (1) Publicly adopt a vigorous stand against chewing tobacco as a major health hazard; and (2) Support appropriate legislative initiatives to cause tobacco containers to carry the warning "chewing tobacco may cause cancer of mouth, throat, and may cause cardio-vascular disease."

Substitute 27 (A-86) Adopted
Organ Donor Legislation
Introduced by Gail Herman, for the Medical Student Section

Directed that the Society cause to be introduced and support legislation encouraging retrieval of organs for transplant.

38 (A-86) Adopted
The Illinois Cooperative Mammography Screening Promotion
Introduced by Jere E. Freidheim, M.D.

Directed that the Society: (1) Recognize the importance of providing information about the Illinois Cooperative Mammography Screening promotion to the families of Illinois physicians and that the House of Delegates members assist in disseminating such information in their communities; and (2) Endorse the American Cancer Society guidelines for breast cancer screening as a means to identify and treat early stage breast cancers.

Report
Filed for information the following report:

Council on Public Relations and Membership Services.

MEMORIAL RESOLUTIONS

The House also adopted memorial resolutions in memory of Drs. J. Ernest Breed, H. Close Hesseltine, Stanley E. Ruzich, Frank C. Sedlak, William S. Smith, Philip G. Thomsen, George C. Turner and Charles J. Weigel, and expressed its profound loss and condolences to their families.

ELECT OFFICERS, TRUSTEES, AMA DELEGATES

Dr. Jere E. Freidheim, Chicago, was installed as ISMS president, succeeding *Dr. Morgan M. Meyer,* Lombard.

Election of Officers
At the concluding session of the House, 1986-87 officers were elected unanimously. They are: *Drs. Allan L. Goslin,* Streator, president-elect; *Harry A. Springer,* Evanston, first vice-president; *Ronald G. Welch,* Belleville, second vice-president; *Harold L. Jensen,* Flossmoor, secretary-treasurer; *Lawrence L. Hirsch,* Northbrook, speaker of the house and *Robert M. Reardon,* Bloomington, vice speaker of the house.

Election of Trustees
Elected trustees were: *Drs. Ross N. Hutchison,* Gibson City, Second District; *James H. Andersen, Audley F. Connor Jr., Robert C. Hamilton* and *Pedro A. Poma,* Third District; *Michael C. Snyder,* Springfield, Fifth District; *Arthur R. Traugott,* Urbana, Eighth District; *Raymond A. Dieter, Jr.,* Glen Ellyn, Eleventh District and *Raymond E. Hoffman,* Rockford, Twelfth District.

Judicial Panel
Dr. Jack L. Gibbs, Canton, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates
The House of Delegates elected AMA delegates and alternates to serve January 1, 1987 through December 31, 1988. Elected delegates were *Drs. James H. Andersen, Audley F. Connor, Jr., Lawrence L. Hirsch, Joseph R. O'Donnell, Pedro A. Poma, Richard Quinones, P. John Seward, Robert M. Vanecko, Fred Z. White* and *George T. Wilkins, Jr.* Elected alternate delegates were *Drs. Juanito S. Bartolome, Jr., H. Constance Bonbrest, James DeBord, Manuel Guerrero, Henrietta Herbolsheimer, Alfred J. Kiessel, William J. Marshall, Joseph B. Perez* and *Ms. Jennifer Souders. Robert M. Reardon* was elected to complete a term expiring December 31, 1987. Elected *Dr. Ronald G. Welch,* Belleville, to complete unexpired delegate term of *Dr. Robert P. Johnson* until December 31, 1987 and *Dr. Allan L. Goslin,* Streator, to serve until December 31, 1987. *Dr. Joan E. Cummings,* Hines, was elected alternate delegate to serve until December 31, 1987.

1987 Dues
The secretary-treasurer announced that the per capita dues for 1987 were set at $273.

Illinois State Medical Society
1986-1987 Board of Trustees

President		Jere E. Freidheim, M.D., Mercy Hospital and Medical Center, Stevenson at King Dr., Chicago 60616
President-Elect		Allan L. Goslin, M.D., Route 4, Streator 61364
1st Vice-President		Harry A. Springer, M.D., 800 Austin St., Suite 610, Evanston 60202
2nd Vice-President		Ronald G. Welch, M.D., 333 S. Illinois, Suite B, Belleville 62220
Secretary-Treasurer		Harold L. Jensen, M.D., 3235 Vollmer Rd., Flossmoor, 60422
Chairman Board of Trustees		Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522

House of Delegates

Speaker		Lawrence L. Hirsch, M.D., 1324 Coventry Lane, Northbrook 60062
Vice-Speaker		Robert M. Reardon, M.D., 1008 N. Main St., Bloomington 61701

Trustees

1st Dist.	1987	David B. Littman, M.D., 1034 Old Elm Road, Highland Park 60035
2nd Dist.	1989	Ross N. Hutchison, M.D., 126 E. 9th St., Gibson City 60936
3rd Dist.	1989	James H. Andersen, M.D., 141 Breakenridge Farm, Oak Brook 60521
	1987	Alfred J. Clementi, M.D., 675 W. Central Rd., Arlington Hgts. 60005
	1989	Audley F. Connor, Jr., M.D., Jackson Park Hospital, 7531 S. Stony Island Ave., Chicago 60649
	1987	Joan E. Cummings, M.D., 11-B—Room 482—Ward 4 West, Bldg. 200—Hines VA Hospital, Hines 60141
	1988	Ulrich F. Danckers, M.D., 1040 Monroe Ave., River Forest 60305
	1989	Robert C. Hamilton, M.D., 711 W. North Ave., Chicago 60610
	1988	William J. Marshall, M.D., 2601 Lincoln Hwy., Olympia Fields 60461
	1987	Arthur R. Peterson, M.D., 2740 W. Foster, Chicago 60625
	1989	Pedro A. Poma, M.D., 1200 Superior, Suite 402, Melrose Park 60160
	1987	Cyril C. Wiggishoff, M.D., 2800 N. Sheridan Rd., Suite 602, Chicago 60657
4th Dist.	1988	Lorris M. Bowers, M.D., 214 NE Glen Oak, Suite 600, Peoria 61603
5th Dist.	1989	Michael C. Snyder, M.D., 326 N. 7th St., Springfield 62701
6th Dist.	1987	George T. Wilkins, Jr., M.D., #1 Glen Ed Prof. Park, Edwardsville 62025
7th Dist.	1988	Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522
8th Dist.	1989	Arthur R. Traugott, M.D., 1107 Eliot Dr., Urbana 61801
9th Dist.	1987	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946
10th Dist.	1987	Thomas P. Meirink, M.D., 8601 W. Main St., Belleville 62223
11th Dist.	1989	Raymond A. Dieter, Jr., M.D., 22 W. Stanton Rd., Glen Ellyn 60137
12th Dist.	1989	Raymond E. Hoffmann, M.D., 1030 Highview Ave., Rockford 61107

Trustee-At-Large	1987	Morgan M. Meyer, M.D., 573 S. Lombard, Lombard 60148

AMA Delegation Chairman *(Ex-Officio)*	Morgan M. Meyer, M.D., 573 S. Lombard, Lombard 60148
ISMIE Board of Governors Chairman *(Ex-Officio)*	Fred Z. White, M.D., P.O. Box 279, 525 Sweetbriar, Chillicothe 61523
ISMIS Board of Directors Chairman *(Ex-Officio)*	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946

Change as Constant

Business matters considered at the 1986 annual meeting of the ISMS House of Delegates are capsulized in the Summary of Actions. This section provides brief synopses of selected special presentations.

Speakers addressing the ISMS House of Delegates represented divergent perspectives. Illinois Governor *James R. Thompson's* comments on legislative and public health issues ranged from infant mortality to tort reform. Illinois House of Representatives Republican Leader *Lee Daniels* (R-Elmhurst) focused on the nature of the legislative process and grassroots political action. AMA President *Harrison Rogers, M.D.,* brought the House up-to-date on organized medicine's national front. Cook County Circuit Court Judge *Edwin Berman,* who has been assigned to implement the Medical Malpractice Reform Act of 1985 in Cook County, recapped efforts to organize malpractice screening panels.

Reducing Infant Mortality

The Governor emphasized the administration's commitment to reduce infant mortality in Illinois, a commitment which was later recognized with a plaque from the Society lauding progress during his tenure.

The Governor reported that the infant mortality rate in Illinois had dropped by 28% since he took office in 1977. Initiatives which had contributed to that progress had included the "Parents Too Soon" program, designed to reach the teen population.

"These are just numbers, and we are talking about saving human lives," he said. "The change in the rate since 1977 really means that thousands more youngsters are alive today due to our efforts." The Governor announced that his proposed budget for fiscal year 1987 included a $24.7 million commitment to the "offensive for life," more than double the amount allocated for FY86.

Governor Thompson complimented the Society's grassroots efforts, which resulted in passage of



ISMS Board of Trustees Chairman Alfred J. Clementi, M.D., presents a plaque to Illinois Governor James R. Thompson for his efforts to reduce the infant mortality rate.



(L-R) Ronald Welch, M.D., Belleville, and Dr. and Mrs. Jere E. Freidheim

the Medical Malpractice Reform Act of 1985. "You were among the most vigorous advocates ever to appear before the Illinois General Assembly," he said. "Organized medicine responded quickly and well," he added, to the need for action from within the profession to streamline the medical disciplinary process in Illinois.

"You need the benefit of deep, radical and permanent changes in how we reform tort law in Illinois," the Governor added. "Virtually every business and governmental unit in the state is affected . . . . the chains are going up before the driveways and entries of the forest preserves and parks. The risks are simply too high to contemplate . . . . I feel a chill every time a school board member tells me, 'Governor, we're going bare when our insurance runs out.' "

Staying Close to Patients

AMA President *Harrison Rogers, M.D.*, stressed the importance of retaining medicine's traditional professional ethic in the face of increasing pressures from business concerns involved in health care.

"We are seeing young physicians today join groups in record numbers," he told the House. "These systems accounted for 20 million people last year. . . . We have to accept the changes which have occurred in health care, communications, transportation and so many other fields," he added, enumerating new challenges, such as federal cost containment legislation, excess physician manpower and the malpractice crisis.

"It is increasingly important that you retain the traditionally close relationship with your patients," he told the House. "The patient must always come first."

Implementing Screening Panels

Cook County Circuit Court Judge *Edwin Berman* traced efforts to establish malpractice case screening panels in Cook County, pending the Illinois Supreme Court decision on the constitutionality of the legislation. He reported that the bar association had assisted in efforts to establish rosters of screening panel volunteers, and that 540 physicians and 440 attorneys had volunteered to serve in Cook County, in addition to the judges who had volunteered to fill judicial slots.

Judge Berman also said that six additional judges would be appointed in the next three months, in order to deal with the growing burden of medical malpractice litigation and cases under the new drunk driving law.

He called upon physicians to volunteer to serve on the screening panels. "We intend to ask the Supreme Court to streamline the hearing process so it would take no more than two days of your time," he told the House. "The more people volunteer to serve, the less often they will be called upon to do so."

Public Affairs Breakfast

Lee Daniels (R-Elmhurst), Republican leader in the Illinois House of Representatives, stressed the importance of continued political involvement. A major proponent of medical malpractice reform, he called upon physicians to recognize the challenges which lay ahead.

"As we wait for the Supreme Court ruling that will reaffirm that the Illinois General Assembly makes laws and not the courts, I believe we will continue to move forward," he



ISMS President Morgan M. Meyer, M.D.: A call to the family of medicine.



Dr. and Mrs. Alfred J. Clementi



Fred Z. White, M.D., Chillicothe, chairman of the ISMS Task Force on Financial Aid to Medical Students, and Lauren Baker, immediate past chairman of the ISMS Medical Student Section, at the raffle to benefit the ISMS Education and Scientific Foundation's medical student loan fund.



ISMS Past Presidents gather for annual gourmet dinner. Standing (L-R) Cyril C. Wiggishoff, M.D., Herschel Browns, M.D., P. John Seward, M.D., George T. Wilkins, Jr., M.D., J. M. Ingalls, M.D., Joseph H. Skom, M.D., Fred Z. White, M.D. and David S. Fox, M.D. Seated (L-R) are C. J. Jannings, III, M.D., Fred Z. Lake, M.D., Immediate Past President Robert C. Hamilton, M.D., Robert P. Johnson, M.D., Leo P.A. Sweeney, M.D. and Willard C. Scrivner, M.D.

told more than 300 physicians and auxilians at the annual Public Affairs Breakfast.

"This is the start of a long fight," he said. "What doctors have faced is what every other association, every local unit of government is facing."

Rep. Daniels told the group that medical malpractice is a highly specialized area in which only a very small proportion of attorneys participate. He pointed to the Illinois Defense Lawyers Association as an example of an attorney group which had supported efforts to enact genuine tort reform.

Among unresolved malpractice reform issues, Rep. Daniels pointed to comparative negligence and the contingency fee structure. He stressed that caps on non-economic losses would be the most difficult element to pass in the legislature.

"No matter what we do," he said, "these arguments always become personalized . . . it's a very emotional experience to debate peoples' rights to recovery."

"There comes a time when society must speak clearly about the rules and regulations under which it must operate," he said. "There comes a time for the legislative body to stand up and be counted and to do what they were elected to do."

The ISMS Education and Scientific Foundation Student Loan Fund raffle was held immediately after the Public Affairs Breakfast. In his brief comments, *Fred Z. White, M.D.,* chairman of the ISMS Task Force on Financial Aid to Medical Students, told the group that the Society and Auxiliary had been able to provide $225,000 in loans to students as a result of accelerated fund-raising efforts over the past three years. First prize in this years' raffle, a weekend for two in New York City, was won by *Buford Hall, M.D.,* Burr Ridge.

The Family of Medicine

"As my term comes to a close, I have a renewed sense of optimism about the future that faces us," *Morgan M. Meyer, M.D.,* told the House in his concluding comments as outgoing ISMS president. "In spite of intrusion by government and third parties, physicians continue to stand by their patients and resist the increasing pressures to undertreat and discharge early. Physicians are maintaining standards of patient advocacy, and are building strong medical staffs, the best weapon in our arsenal against unreasonable hospital demands."



Lee Daniels (R-Elmhurst), House Republican Leader: A time for the legislative body to stand up and be counted.



ISMS Auxiliary President Suzanne Meirink and ISMS Tenth District Trustee Thomas Meirink, M.D.

"In the face of a monumental flood of litigation, you undertook an effort that was thought by many to be worthless," he continued. "You took on one of the biggest lobbies in Springfield and you won."

"Other legislation that is important to us will be necessary," he went on. "So continue your work in the trenches, educating each other and your patients. And pull back from some of your reticence with the media. We need them and they

need us to get a balanced, accurate picture of what medicine really needs and what health care is all about."

Dr. Meyer concluded his comments with a call for unity. "Although many of the members' faces I saw on the President's Tour this year were filled with apprehension, uncertainty or even anger over the current tumult in the health care field," he said, "I also saw and heard true camaraderie and determination to see this thing through. . . . We need the family of medicine as never before."

A Noble Profession

Newly inaugurated ISMS President *Jere E. Freidheim, M.D.,* called for action and vigilance in areas of concern facing modern medicine.

"During the coming year, we will be continuing to address challenges in the areas of medical liability, alternative health care contracts and medical discipline," he told the House. "As we await the decision of the Illinois Supreme Court, we look ahead to further, meaningful tort reform. Even though many other areas are being affected by the liability problem, we cannot rely on others to do the work for us. Our energies should be channeled into the areas of public education and legislative persuasion."

"As the business of medicine grows, we face an ever-widening array of alternative health care financing contracts," Dr. Freidheim said. "It is imperative that we be allowed to openly discuss their terms and evaluate their intent as a profession. But current antitrust laws effectively may prohibit this sharing of information among us," he said.

"Last year, our state medical society drafted legislation which would lessen these antitrust concerns and facilitate free flow of information on how financing contracts affect us as doctors—and the care we can provide our patients," Dr. Freidheim continued. "Our legislation failed, but hopefully we will be able to be successful with it this year. It is a priority which demands our attention and action. Otherwise, we will be forced to relegate medical concerns to business constraints."



Drs. Morgan and Carol Meyer at the annual President's Night dinner held in his honor.



Dr. and Mrs. Lawrence L. Hirsch

Public Affairs Committee Chairman Albert W. Ray, M.D., Joliet, introduces Rep. Lee Daniels.





Mr. and Mrs. Alexander R. Lerner



Newly inducted members of the ISMS Auxiliary Board.

Tending to the Garden

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

Folks in Mount Hawley don't brag about themselves. It just wouldn't hold up. They do hope someone else will brag about them, but that don't happen, and it wouldn't hold up either.

Children, however, are always legal bragging material. When you meet one of our citizens on the street, that hand moving with all due speed toward the back pocket isn't going to produce a gun—or a wallet—but pictures (always plural) of children or grandchildren. Powerful bragging material!!!

Kids at school—Lord, I've had more grades told to me, graduations described—cum laude's, super laude's and a few sub laude's.

Last week Willard brought one to the 10 o'clock coffee roundtable that just seemed out of step with the usual bragging. Seems like his second daughter, Estelle, a psychology major at Urbana, was taking extra courses. "So she will know more?" asked Chick. "No, so she can charge more," returned Willard, without even so much as a hint of a question in his voice. The thought of getting more education just so she could charge more for what she did put a chill on the round table. "She don't really care much about this psychology stuff, but she figures she can make pretty good money until she analyzes the right man." Probably meant to be humorous, but it didn't ring up anyone's funny bone.

Asa dusted the sugar from his donut off his bibs, a sign he was going to say something, and tightened his hat, a sure sign he was going to leave after that say. "Depends on what drives you. Sometimes I mow the lawn because Maude chases me out with a broom, but I tend to my garden because I enjoy it. The fun is in the doing—even more than in eating all them radishes. People with more learning call that motivation, that what drives you. But I'd sure hate to think that what was driving the person taking care of me was money, and not the love of tending to the garden in my head . . or body!" And he did leave.

That was so profound that it was followed with a few comments about folks that dance to different tunes or hear that beat of a different drummer. Then Willard left.

Well, I slipped into a semi-trance, sipping my coffee and thinking about some of the medical things I've read. Sometimes it seems to me that a tendency is developing for medical service to be fund-driven—rather than care-driven, if you get what I mean. I certainly hope that the driving force is a desire to help people, to make them better or to help them endure what can't be improved. I know it's not so with Doc Frank, but I would be deeply depressed if I thought that there were doctors out there caring for people in any way simply because money was available for that care. That wonder comes to me when I read of all of these members of the health care team. Generally Doc Frank and Emma, his nurse, do all of that, acting as social worker, counsellor, nutritionist, exercise instructor, all of that!! Do you suppose that if we had funds available for all those types here in Mount Hawley, that all of them would appear, just to pick up that money for doing what Doc does now.

I suppose it would happen! Scarey! To think of all of those people in my garden!! I'll try to climb from the depths of this depression and write on a more up-beat note soon. ◀

Yours,
E. Goodwins.

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Edward J. Lennon, MD
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Mammography Screening Promotion

By Pat Spadoni (Mrs. Alex)/ISMSA President

The Illinois State Medical Society, with the wholehearted support of the Illinois State Medical Society Auxiliary, has joined the Chicago Medical Society, the Illinois Radiological Society, Illinois Society of Pathologists and Illinois Chapter, American Cancer Society, in sponsoring the Cooperative Mammography Screening Promotion (CMSP). This effort is designed to encourage women physicians and female members of physician families to obtain mammograms consistent with American Cancer Society guidelines. It is also intended to provide education about the value of this important health habit in early detection of breast cancer.

It has been estimated that 6,500 Illinois women will develop breast cancer and 2,100 will die from the disease in 1986. Studies have shown that only 25% of women regularly practice self-breast examination. In addition, tumors discovered by self-examination are ordinarily more advanced than those identified by mammography, as mammography can reveal tumors before they are palpable.

The various organizations listed in the introduction to this month's article support the American Cancer Society (ACS) screening recommendations. These call for a baseline mammogram in asymptomatic women once between the ages of 35 and 40, every year or two between the ages of 40 and 50, and annually thereafter.

A recent survey of Illinois primary care physicians revealed that only 15% were ordering mammograms at these intervals. Only 5% of women are taking advantage of this vital screening test, although it is widely available in Illinois.

It has been said that mammogram screening is expensive and exposes the patient to a high level of radiation. However, according to a recent American Cancer Society survey, 98% of Illinois facilities are safely performing mammograms within the Society's low-dose guidelines. Some progress has been made in reducing cost; in 1985 the average charge for mammography was $105.

The expense is truly worth the results, as evidenced in a recent joint project between the American Cancer Society and a Chicago television station. During the joint mammography promotion in Chicago, 9,300 examinations were done in a one month period. A total of 47 breast cancer cases were discovered, 70% in the early stages. Many of these women would never have known that a problem was developing without the mammography screening.

Project sponsors have encouraged auxiliaries and hospitals around Illinois to join the promotion and offer educational programs about mammography and breast health. Several are making their members and communities aware of the importance of the test and ways to maintain a preventive health program. I urge all ISMSA members and other women in their families to follow the American Cancer Society mammography guidelines, and to set an example for all women in seeking the benefits of early detection ◀

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. . . we ask you to consider using PRN the next time you want a specialist. We started PRN after learning a few things: that when you need a specialist, you want immediate access; that you want frequent updates on your referred patients; that you want a number you can call for information without red tape; and that you want your patients returned to your practice.

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We think we can assist your patients, also. We think your patients will appreciate being referred to an academic medical center in a suburban area with ample parking. We think they will enjoy the easy drive on I-94 or the many Illinois highways that lead into Wisconsin Highway 15 to our scenic campus. We think you'll find that, for most northern Illinois communities, we're as close as Chicago.

We hope we can assist you. By calling PRN, **1-800-472-3660** (in area codes 815, 312, 309), we'll make all the arrangements to refer your patient to one of our specialty programs. Our faculty will always be available to lend the kind of assistance you request.

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HMSS Has Impact at ISMS Annual Meeting

The ISMS Hospital Medical Staff Section played an important role during the recent meeting of the Society's policy-making House of Delegates. The Section's prominence is expected to increase as more medical staffs choose representatives to join in their deliberations and formulate proposals on medical staff issues.

Both proposals initiated by the ISMS Hospital Medical Staff Section were adopted by the ISMS House of Delegates at its April 4-5 annual meeting. The resolutions were originally submitted by Drs. Allan L. Goslin and Albino T. Bismonte at the first annual meeting of the HMSS on March 1.

As a result, ISMS policy now supports a significant role for the medical staff in hospital risk management programs and directs that the Society pursue legislation to establish a reasonable statute of limitations for malpractice suits brought on behalf of minors.

"Passage by the House demonstrates that ISMS wants the input of grassroots physician members through several mechanisms, including the medical staff section," said HMSS Delegate Silvana Menendez, M.D., who introduced the resolutions. "I am enthused because this may encourage more medical staffs to participate in the Section."

The House took action on several other resolutions dealing with medical staff matters as reported elsewhere in this issue. These included a resolution concerning premature hospital discharge due to pressures from third parties. The adopted resolution states:

"*RESOLVED,* That ISMS: (1) communicate to its membership and to the public, a physician's rights and responsibilities concerning patient discharge, stressing that a physician is under no obligation to discharge patients prematurely and that only a patient's physician is entitled to authorize discharge. Financial and other pressures must not be allowed to jeopardize the welfare of the patient; and (2) Act to oppose the pressures on physicians to inappropriately discharge patients and make the public aware of these pressures."

The ISMS HMSS will meet in caucus on each morning of the AMA HMSS Annual Meeting at the Hyatt Regency Hotel in Chicago. A light breakfast will be served at the caucuses, which are scheduled for 7:00 a.m., Friday, June 13 and 7:30 a.m., Saturday, June 14.

All Illinois hospital medical staffs are urged to send a representative to the meeting. The representative must be an ISMS member with active clinical privileges who has been selected by the medical staff. For further information contact ISMS at (312) 782-1654.

Illinois HMSS Holds Inaugural Annual Meeting

The Hospital Medical Staff Section, created by the ISMS House of Delegates in April 1985, held its first annual business meeting on March 1, 1986. Sixty-four medical staffs were represented.

Special guest and keynote speaker Thomas R. Reardon, M.D., AMA HMSS delegate, addressed the Section on national goals and achievements and encouraged involvement.

Alfred J. Clementi, M.D., chairman of the ISMS Board of Trustees, urged that Section members continue the hospital-based political and legislative work which had led to passage of legislation reforming medical malpractice law in Illinois. He also discussed recent ISMS efforts to enhance the effectiveness of the medical disciplinary system.

Other speakers addressed media relations, physician contracting and changes in the malpractice insurance policy offered by the physician-owned Illinois State Medical Inter-Insurance Exchange.

The ISMS HMSS reviewed eight resolutions, two of which were approved for submission to the AMA HMSS. One stipulates that AMA commissioners to the JCAH include a member of the AMA HMSS governing council. The other calls for a policy requiring that medical staff privileges be based on clinical competency and quality of care rather than "productivity."

The Section held elections for four of the ten governing council positions. Thomas C. Malvar, M.D., was elected secretary. Allan L. Goslin, M.D., was named treasurer. Albino T. Bismonte, M.D. and Lawrence A. Stone, M.D., will serve as at-large members.

"Our experience with the first annual meeting shows that medical staffs will be a strong voice in the Illinois State Medical Society," commented Raymond A. Dieter, Jr., M.D., HMSS chairman. "We now need to expand participation to include representatives of each hospital medical staff in Illinois." Dr. Dieter has urged that all staffs send a representative to the June 13-14 AMA HMSS meeting. ◀

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PRECAUTIONS
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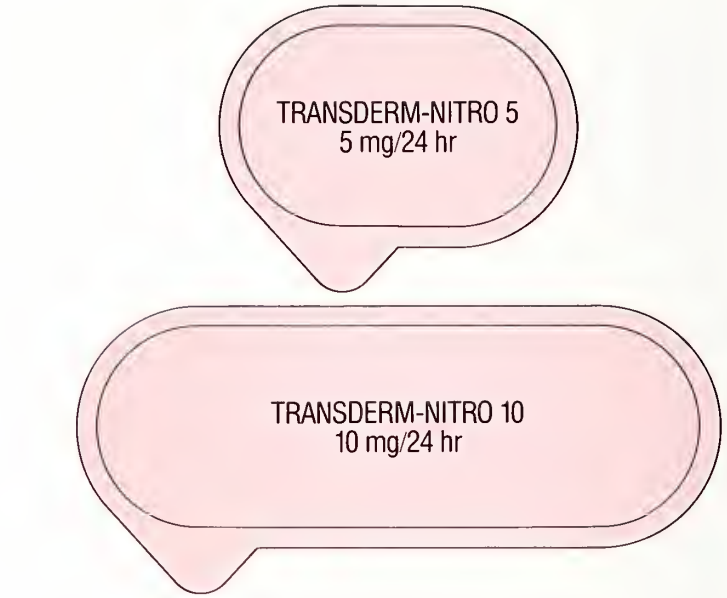
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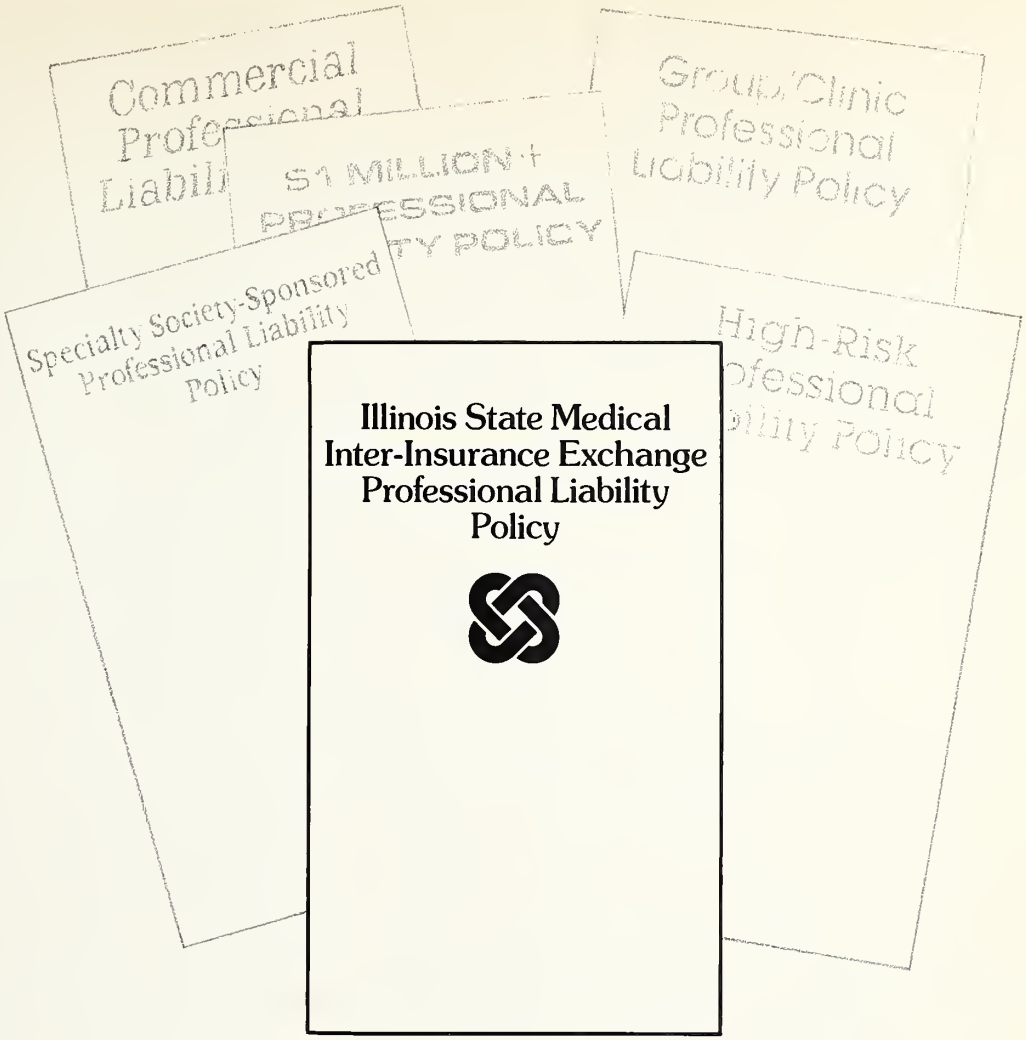
Dosage should be titrated to individual patient's needs

starting doses



titration doses





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Association with Low-Weight Birth Rate and Adolescent Pregnancy

Infant Mortality

By Dipali V. Apte, Delegate/Rush Medical College

From 1900 to 1950, the U.S. infant mortality rate dropped from 100 to 50 per 1000 live births.[1] This decline was due largely to a decrease in infant deaths in the postneonatal period (28 days to 11 months of age).[2] Evidence suggests that these deaths were due primarily to environmental factors, rather than low birthweight (less than 2500g).[1] Deaths in the neonatal period (0 to 27 days) are largely due to immaturity, and low birthweight indicates immaturity.[3] In 1950, low birthweight infants accounted for two-thirds of neonatal deaths, but only 7.5% of all births. Low birthweight infants are at increased risk of neurodevelopmental handicaps,[1] congenital anomalies, and lower respiratory tract infections.[4]

From 1965 to 1980, the infant mortality rate in the United States dropped from 24.7 to 13.1 per 1000 live births. This was attributed to special neonatal intensive care services, rather than a reduction in the rate of low-weight births.[4]

Preventing low-weight births is economically and medically more feasible than sustaining the lives of infants vulnerable to serious handicap.[1] Low birthweight infants are five times more likely to die in the first year, and very low birthweight infants (1500g or less) are 200 times more likely to die in the first year than normal-weight infants.[2]

Infant mortality and low-weight birth rates are particularly problematic in Illinois, and specifically Chicago. Infant mortality rates in 1982 were 11.2 per 1000 live births for the United States as a whole, 13.6 for Illinois, (10.7 for whites and 24.5 for blacks) and 18.6 for Chicago (12.2 for whites and 25.7 for non-whites). In 1984, the infant mortality rate for Illinois as a whole was 12.0, and 20.4 for blacks. While the low birthweight rate for the United States as a whole has declined, (from 7.1 to 6.8 per 1000 live births from 1977 to 1982) the rate in Illinois has remained at 7.5 per 1000 live births, and the rate in Chicago has increased from 10.2 to 10.5 per 1000 live births.[3]

Despite statewide declines in the infant mortality rate, there has been little decline in the rate of postneonatal deaths, no change in the rate of low-weight births, and the gap in the rates between whites and non-whites has not decreased. Regardless, the Surgeon General specified in 1980 that the national infant mortality rate be reduced from 12.0 to 9.0 per 1000 live births (and 12.0 per 1000 live births for non-whites) by 1990. A concurrent target rate of 5.0% low birthweight infants for all births was also set. Illinois may not be able to achieve this goal, given the current rates of decline of the infant mortality rate, unless the rate of low-weight births declines more rapidly than it has in recent years.[3]

The causes of low birthweight are not known. However, a great deal is known concerning risk factors. Teenage mothers are at the highest risk, especially those under 17 years of age. Socioeconomic status (social class, income, education and census tract) correlates with an increased risk for premature delivery and intrauterine growth retardation. At least 12 years of education sharply

Infant Mortality Focus of Statewide Effort

Illinois Governor James R. Thompson told the ISMS House of Delegates on April 4 that his administration would pursue its commitment to reducing the infant mortality rate in Illinois.

ISMS Board of Trustees Chairman Alfred J. Clementi, M.D., presented a plaque to the Governor in recognition of his progress in reducing the Illinois infant mortality rate.

The Governor reported that his proposed FY87 budget would include $24.7 million for the "offensive for life" program, targeted to the 19 Chicago, three suburban and five downstate communities with the highest infant mortality rates. He reported that the state's infant mortality rate had dropped 28% since he took office in 1977, when it had stood at 15.9/M, and is expected to drop to 11/M by the end of 1986.

The Governor also described the Illinois "Parents Too Soon" program, designed to educate and help adolescent childbearers in Illinois. The project was initiated in 1984 and reached 25,000 teens in 1985, a 37% increase over the first year. A new system of service networks is expected to enable public health officials to assist 1700 more young women in FY86. ◀

reduces the risk of low birthweight. Women who are unmarried have a significantly greater risk of bearing low birthweight infants. Blacks are more likely to begin childbearing as adolescents, have lower birthweight infants, be of a low socioeconomic status, have less education, and remain unmarried.[4]

In 1970, births to teenagers accounted for 21.5% of all births in the United States. This percentage rose to 22.6% in 1978, and represented 19.9% in 1982. The percentage of births to black teenagers was 28.6% of all black births in 1982, when the percentage for white teens was 12.5 of all white births.[5] Maternal age is an important determinant in infant mortality; again, this is principally because teenage mothers are more likely to give birth to low-weight infants.[6]

The ramifications of adolescent pregnancy go beyond the issue of infant mortality. In 1976, teenage abortions represented 32% of all abortions. Teenage mothers tend to withdraw from school before graduating. Without a complete education they frequently become dependent on public aid. If employed, their jobs are likely to pay, on the average, only half what those who bear children after the age of 20 earn; teen mothers, in turn, subsist in poverty.[5,8] There is an additional emotional and/or monetary stress on the family or parent of a low birthweight infant, largely due to the increased health care needs of the infant.[9] Chronically ill children can adversely affect parental employment opportunities, as well as marital stability.

Mother-child bonding is decreased[9] with a low birthweight infant. This can give rise to an abnormal relationship[10] which, along with the socioeconomic and environmental factors, perpetuates a vicious cycle of adolescent pregnancy and/or teenage parenthood.[11] The children of adolescent parents are themselves at an increased risk of becoming adolescent parents.

Given this background for Illinois, it is imperative that adolescent pregnancy be addressed both for its own sake and in order to decrease the low-weight birth and infant mortality rates. Medical students can play a key role in helping to solve these problems by learning to teach sex education to junior and senior high school students. By participating in the growing number of programs in Illinois, and especially in the service projects sponsored by the MSS, medical students can broaden their horizons and contribute significantly to resolution of one of this state's more pressing problems. ◀

References

1. McCormick, M.C.: "The Contribution of Low Birthweight to Infant Mortality and Childhood Mortality," *New England Journal of Medicine* 312:2, 82-90, 1985.
2. Morris, J.N., Heady, J.A.: "Social and Biological Factors in Infant Mortality. 1. Objectives and Methods," *Lancet* 1:349-9, 1985.
3. Illinois Department of Public Health, Interagency Committee Advisory Task Force on Infant Mortality Reduction: *Infant Mortality Reduction for the State of Illinois—Report to Governor James R. Thompson,* 1-46, September 1985.
4. Institute of Medicine Committee to Study the Prevention of Low Birthweight: *Preventing Low Birthweight: Summary,* National Academy Press, 1-41, 1985.
5. Commission for Health Planning and Resources Development: *Health Systems Plan for the City of Chicago. 1984-7.* City of Chicago Health Systems Agency, 78-98, 1984.
6. Eberstein, I.W., Parker, J.R.: "Racial Differences in Infant Mortality by Cause of Death: The Impact of Birthweight and Maternal Age," *Demography,* 21:3, 305-21, 1984.
7. Center for Population and Family Health: *Preventing Adolescent Pregnancy: The Role of the Family,* Colloquium, Columbia University, June 19, 1981.
8. Withington, A.M., Gimes, D.A., Hatcher, R.A.: *Teenage Sexual Health,* Irvington Publishers Inc., 61-101, 1983.
9. Siverman, W.N.: "Incubator Babe Side Shows," *Pediatrics* 64:127-41, 1979.
10. Escalona, S.K.: "Babies at Double Hazard: Early Development of Infants at Biologic and Social Risk," *Pediatrics* 70:670-6, 1982.
11. Stengel, R.: "The Missing-Father Myth," *Time* 90, December 9, 1985.

Viewbox

(Continued from page 261)

Diagnosis: (2) Microcystic Adenoma of Pancreas

The surgical specimen (Fig. 2) shows the mass, which contains numerous small cysts. The pathological diagnosis was microcystic adenoma of the pancreas. While some adenocarcinomas of the pancreas contain areas of low attenuation caused by tumor necrosis, these areas are usually irregularly shaped and small relative to the solid portion of the tumor.[1] Therefore adenocarcinoma of the pancreas is not the most likely diagnosis.

Patients with pseudocysts usually have histories of symptoms due to recurrent pancreatitis or a history of trauma.[1,2] Pseudocysts are usually unilocular, round low density masses with walls of uniform width.[1] Atypical pseudocysts may contain irregular walls and septa so that they resemble cystic tumors.[1,3] The lack of a suggestive medical history and the numerous tiny cysts in this pancreatic mass make pseudocyst an unlikely diagnosis.

Islet cell tumors frequently produce endocrinologic disturbance.[3] They may be too small for detection by CT, but when they are larger they are visible as densely enhancing masses.[1,3] Such tumors may undergo central necrosis and appear as unilocular or even multilocular cystic masses with thickened walls.[1] The absence of a distinct clinical syndrome and the lack of intense contrast enhancement indicate a diagnosis other than islet cell tumor.

Mucinous cystic neoplasms of the pancreas were formerly subdivided into cystadenomas and cystadenocarcinomas. They are most common in 40 to 60-year-old women although patients as young as 20 years old have been reported. The majority occur in the pancreatic tail and less than 5% are found in the head.[2,4] These tumors are well encapsulated, unilocular or multilocular masses containing large cysts with a columnar mucinous epithelial lining, filled with mucin, hemorrhage and necrotic debris.[1,2] The outer cyst wall is smooth but often contains focal areas of thickening. The internal surface occasionally demonstrates multiple papillary excrescences. Crescentic peripheral calcifications are occasionally seen.[2] Since strict pathologic distinction between cystadenoma and cystadenocarcinoma is not possible, complete surgical excision is the treatment of choice. In the patient presented here, the cystic spaces are very small and contain no debris or focal solid areas. Mucinous cystic neoplasm is a less likely diagnosis.

The correct answer is microcystic adenoma of the pancreas. Microcystic adenomas are benign neoplasms which demonstrate a 2:3 female predominance with a wide age range. The most common presenting symptoms are abdominal pain or vague discomfort with or without back pain, weight loss or nausea. The most common clinical impression is simply an abdominal mass.[5] Incidence in the head, body and tail of the pancreas is roughly equal. They are typically well-circumscribed tumors containing numerous cysts measuring less than 1mm to about 2cm in diameter. The cysts are filled with thin clear fluid. Periodic acid-schiff stain demonstrates large quantities of intracytoplasmic glycogen in the cells lining the cysts. Well formed papillae are not found.[5] There is often a central stellate scar which, when calcified, is visible as a "sunburst" calcification on radiographs.[3-5] Microscopically, pancreatic islets, acini and ductal structures are trapped in these radiating bands of connective tissue.[5]



Figure 2—The cross sectioned pathologic specimen shows mass (arrows) with multiple small cysts that were demonstrated by CT (Figure 1).

Treatment remains controversial. The pathologic and radiologic literature emphasize the benign nature of the neoplasm and recommend no surgical treatment if the diagnosis can be established by biopsy or aspiration cytology and the neoplasm is not obstructing or compressing vital structures.[1,4,5] The surgical literature emphasizes the malignant potential of all cystic pancreatic neoplasms in general and recommends total excision.[6]

References

1. Itai, Y., Moss, A., Ohtomo, K.: "Computed Tomography of Cystadenoma and Cystadenocarcinoma of the Pancreas," *Radiology* 1458:2,419-425, 1982.
2. Compagno, J., Oertel, J.: "Mucinous Cystic Neoplasms of the Pancreas with Overt and Latent Malignancy," *Am J Clin Pathol* 69:573-580, 1978.
3. Ziriwsky, K., Albiri, M., Baer, J.: "Computed Tomography Demonstration of Pancreatic Microcystic Adenoma," *Am J Gastroenterol* 79:2,139-142, 1984.
4. Wolfman, N., Ramquist, M., Karstaedt, N., Hopkins, M.: "Cystic Neoplasms of the Pancreas," *AJR* 138:1,37-41, 1982.
5. Compagno, J., Oertel, J.: "Microcystic Adenomas of the Pancreas," *Am J Clin Pathol* 69:289-298, 1978.
6. Taft, D., Freeny, P.: "Cystic Neoplasms of the Pancreas," *Am J Surg* 142:1,30-35, 1981.

EKG

(Continued from page 262)

Answers: 1. C 2. E

This ECG shows a sinus rhythm with a normal PR interval and slight sinus arrhythmia. The QRS duration is normal. The apparent distortion of the QRS is caused by a marked ST segment elevation seen in the precordial leads V_1 to V_4, especially V_2 and V_3. This is an acute anteroseptal myocardial infarction that is 15 hours old by the patient's history.

All of the statements in question two are true. After a small dose of morphine, the patient's blood pressure dropped. This could suggest the start of cardiogenic shock in the presence of an acute anteroseptal myocardial infarction. Dopamine and careful administration of intravenous fluids were started with some improvement in the blood pressure. Endotracheal intubation was performed. The pulmonary artery catheter was inserted and the patient was transferred to the coronary care unit. The blood pressure fell again and the intra-aortic balloon pump was placed to help support the patient.

Measurements from the pulmonary artery catheter after the balloon counterpulsation, dopamine, fluids, and endotracheal intubation were: pulmonary artery 50/35mmHg, pulmonary capillary wedge 32mmHg, and cardiac index 1.8 liters/minute/meter.[2] The elevated wedge and pulmonary artery pressures rule out hypovolemia as a cause of the hypotension. The depressed cardiac index despite maximal medical support was caused by severe myocardial depression resulting from the myocardial infarction. This is cardiogenic shock. There was no evidence on physical exam, by hemodynamics or oxygen analysis, to suggest mitral regurgitation or a ventricular septal defect. Further hypotension occurred over the next several hours and the patient died. Despite maximal medical management this patient's cardiac index was less than 2 liters/minute/meter[2] which speaks for profound shock. The use of the intra-aortic counterpulsation for cardiogenic shock represents an advance in therapy. However, the results have been mixed because of the severe myocardial damage usually associated with cardiogenic shock. In cardiogenic shock, as few as 20% of patients treated with the pump can be subsequently weaned from this support.[1] Intra-aortic balloon counterpulsation is still an effective means to help stabilize the patient. It can allow time for surgical consideration of any mechanical defects present as well as titration of medications. ◀

Reference

1. Scheidt, Stephen: "Preservation of Ischemic Myocardium with Itra-Aortic Balloon Pumping," (Editorial), *Circulation* 58:211-214, 1978.



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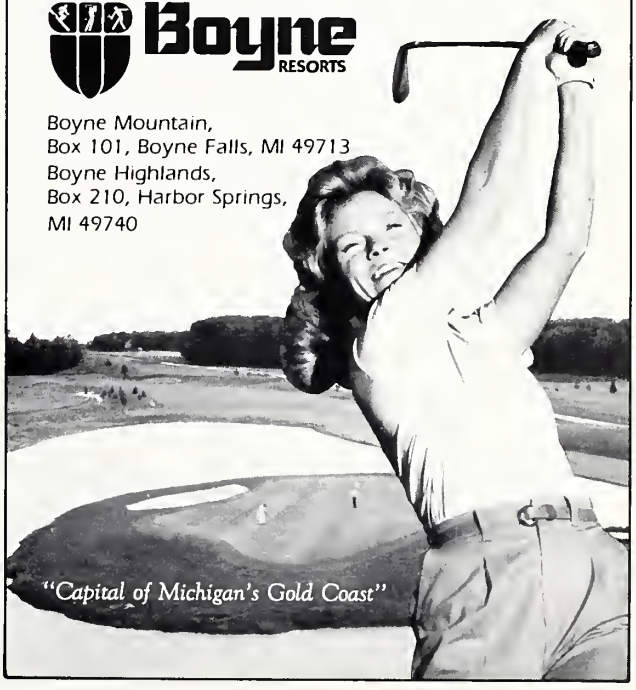
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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education (DRE)

Medical Disciplinary Orders

- *William Robert Ameen* (lic.# 036-064338)
  Effective March 19, 1986, Dr. Ameen's medical license was indefinitely suspended.
- *Reynaldo Anasco* (lic.# 036-047367)
  Effective February 19, 1986, Dr. Anasco's medical license was revoked.
- *Robert John Barnes* (lic.# 036-40140 & 003-036-40140)
  Effective March 24, 1986, Dr. Barnes' medical and controlled substance licenses were revoked.
- *Nellie Calmell* (lic.# 036-058450 & 003-036-058450)
  Effective March 6, 1986, Dr. Calmell's medical and controlled substance licenses were suspended, pending a hearing.
- *Gamal K. Garas* (lic.# 036-53815)
  Effective February 19, 1986, Dr. Garas' medical license was revoked.
- *Jaroslav Herda* (lic.# 036-41593)
  Effective February 19, 1986, Dr. Herda's medical license was suspended for an indefinite period.
- *James G. Middleton* (lic.# 036-38955)
  Effective March 19, 1986, Dr. Middleton's license was ordered to remain revoked and he was prohibited from submitting another restoration request for 5 years.
- *Mahtab Ahmed Mufti* (lic.# 036-48920)
  Effective February 19, 1986, Dr. Mufti's medical license was revoked.
- *Alden Schewe* (lic.# 036-38463)
  Effective February 19, 1986, Dr. Schewe's medical license was revoked.
- *Jason D. Smith, D.O.* (lic.# 036-057474 & 003-036-057474)
  Effective March 24, 1986, Dr. Smith's medical license was indefinitely suspended and his controlled substance license was revoked.
- *James Spindler* (lic.# 036-55217 & 003-036-55217)
  Effective March 24, 1986, Dr. Spindler's medical license was placed on indefinite probation and his controlled substance license was suspended indefinitely.
- *Michael J. Swango* (lic.# 036-069819)
  Effective March 19, 1986, Dr. Swango's medical license was revoked.

(Source: Orders received by ISMS from DRE.)

From the Department of Alcoholism and Substance Abuse (DASA)

Status of Triplicate Prescription Control Program

Two recent reports released by DASA provide a look at the implementation and effectiveness of the new triplicate prescription control program. Facts provided by the reports indicate that:

—The number of stolen triplicate prescriptions which were fraudulently cashed at Illinois pharmacies has decreased by over 80%.

—In the majority of cases, stolen triplicate prescriptions have been used to acquire hydromorphone or phenmetrazine, which are the most sought-after street drugs in Illinois.

—Diverted units of these drugs have dropped substantially from the previous year.

—Over 10,000 triplicate prescription order forms are expected to be submitted to DASA.

—Illinois currently ranks 47th among all states in per capita consumption of the Schedule II and Schedule III narcotic prescription drugs monitored by the U.S. Drug Enforcement Administration through its ARCOS program.

—Of the drugs monitored by ARCOS, Illinois' per capita consumption of the following drugs has decreased: codeine, methylphenidate, amobarbital, cocaine, hydrocodone, secobarbital and oxymorphone.

—Illinois has seen an increase in the per capita consumption of 3 drugs, with phenmetrazine having the largest increase.

(Source: Correspondence from DASA Triplicate Prescription Control Section)

From the Department of Corrections (DOC)

The DOC is interested in receiving proposals from health care providers for comprehensive health services to correctional facilities located in Dwight and Pontiac, Illinois.

Persons interested in submitting proposals or getting further information should contact Tom Hutchison, Deputy Director, Administration and Planning, Department of Corrections, P.O. Box 4902, 1301 Concordia Court, Springfield, IL 62708-4902.

(Source: Correspondence from DOC)

From the Prairie State Games Office

The finals for the 1986 Prairie State Games will begin with opening ceremonies on July 16, 1986. This event, an Olympic-type competition for Illinois athletes, will be held July 17-20 in Champaign. Physician volunteers are sought to provide medical supervision and care of injuries for at least 2-day periods during the Games. Uniforms will be provided to volunteers.

In addition, a seminar will be held July 15, from 7-10 p.m., at the Carle South Clinic Building, Urbana, 3rd floor lounge. This seminar is CME accredited and will focus on the identification, use and abuse of drugs in athletic competitions. Featured speakers include Robert Voy, M.D., U.S. Olympic Committee Chief Medical Officer; Bob Goldman, D.O.; James Leonard, M.D.; and Steve Soboroff, M.D. There is no registration fee.

More information on the Prairie State Games may be obtained by contacting Edward Grogg, M.D., Carle Clinic Association, 602 West University Ave., Urbana, IL 61801, or calling 217-337-3342.

(Source: Correspondance from Prairie State Games Medical Director)

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Job Hunting for the Medical Assistant

By Robin Bluestein, CMA-C

As a recent participant in the medical assisting job market, I wanted to share my experience with others in my situation, as well as the physicians who will be hiring these individuals. Success is rooted in experience, solid preparation, job interviewing skills and, once hired, making the most of your position. In addition to organizing your job search, "being in the right place at the right time," is a great advantage. As the applicant has little control over the latter, it is wise to focus on the former: experience, preparation/planning, job interviewing and making the most of your job after being hired. Part two of this series will be published in the July issue.

Certainly, if this is your first experience in searching for a job, you will have no prior knowledge as to what you must do to prepare. If you are a recent graduate from a medical assisting program, you know the kinds of responsibilities you can expect. You will have a medical assisting education and practical experience through an externship in physicians' offices. You will have undoubtedly chosen whether you would like a job administratively and/or clinically. You will know that a position asking for an individual to do laboratory work, EKGs and vital signs will not be for you if you have decided you would like to do front office work.

Job experience will play a part in the type of position for which you will apply. Some jobs require several years of experience while others require none. Medical assistant certification is becoming more important in the job market as more and more positions require it. Physicians can expect a certified medical assistant to be proficient in the skills they will perform in their job setting. Although certification is not mandatory, it demonstrates an interest in excellence.

In order to retain their certification credentials (beginning in 1988), medical assistants must either take the examination every five years or attain a set number of continuing education units (by attending seminars, courses and reading appropriate material) in a five year period. An individual hiring a "certified medical assistant" will be offering more, both in responsibilities and financially, than one hiring a "medical assistant." If you are not yet certified, make certification a short-term goal!

The next step is preparation and planning. Begin with your resume. A resume is not a one-time endeavor. It should be a document that can be continuously updated as you reach goals in your career path. If you have had no experience in writing a resume, consult with a friend who has and/or research books on the subject. Many books will give you outlines for resume writing.

After typing your resume, begin to check the advertisements (I find the Sunday paper offers the most and the best positions). Some ads state very little about a position and some state what the entire position entails. An ad might state: MEDICAL ASSISTANT call JOAN 976-1212. Another ad might state: CERTIFIED MEDICAL ASSISTANT, Lab work, EKGs, patient contact, light typing, salary commensurate with experience and ability, many benefits, send resume to. . . .

There are many things to consider when answering an ad. Will you answer every position offered for a medical assistant or stick with those with responsibilities of interest to you? What are the stated responsibilities? Are they tasks you can accomplish or can learn? With whom will you be working—a specialist, general practitioner, one physician or many physicians? Will it be a "one girl" office or does the practice employ many individuals? Where is the practice located—near your home, near public transportation or must you drive? Does the position you are applying for have room for advancement? Many of these questions will be answered in the ad and many will be answered in a phone conversation and/or interview. You must consider these questions and many others you will come up with yourself.

The advertisement will either state an individual to call for more information or ask that you send a resume to a certain address. In the former instance, be prepared to ask any questions during the phone conversation. If the individual has an interest in you, expect to be called in for an interview. If a resume is necessary, be sure to include a cover letter. As with the resume, research books will help you with typing a cover letter.

Look to the July issue for part two of this series, which will focus on job interviewing and making the most of your job after being hired.

Information regarding the Illinois Society and/or medical assisting can be obtained from Ehlma Garcia, CMA, EMT-A, president, Illinois Society, 6134 South Tripp, Chicago, Illinois 60629, Robin Bluestein, CMA-C, Co-Chairman, Public Relations Committee, 2247 West Estes, #2, Chicago, Illinois 60645 or Catherine M. Hill, CMA, Co-Chairman, Public Relations Committee, 900 South Plum Grove Road, Palatine, Illinois 60067. ◀

Now and Then



The guy who used to chop a winter's supply of fuel by hand has a son who uses a chain saw to prune his shrubs.

People used to whistle while they worked. Now they wear earphones.

The excuse for missing homework used to be "the dog ate it." Now it's "the disc got erased."

Doctors used to be concerned with saving lives. Now we are concerned with keeping hopelessly ill persons alive too long.

There is a widely held view that under certain clearly defined circumstances, artificial hydration and nutrition could be considered extraordinary and therefore morally non-obligatory.

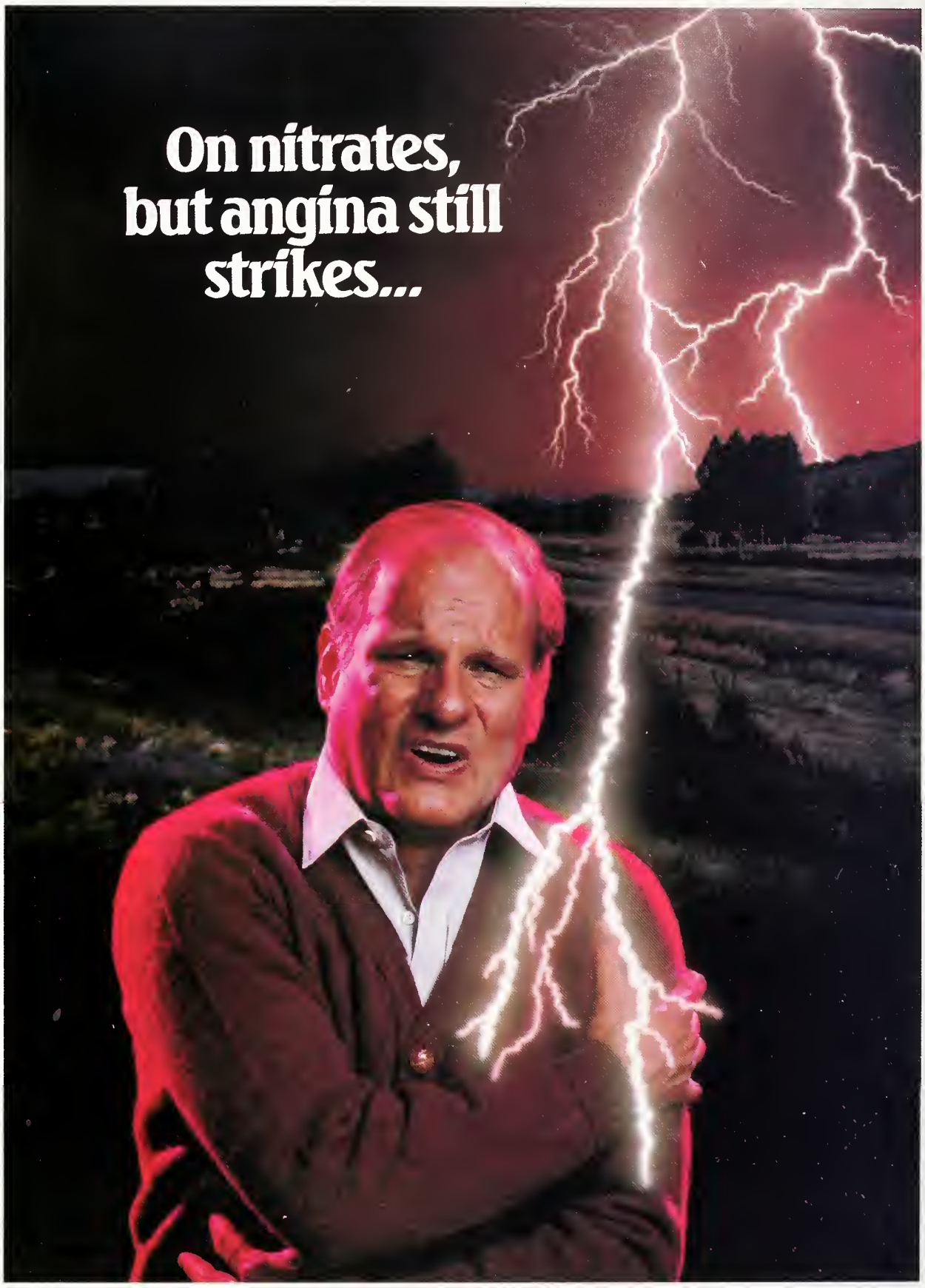
Withdrawing food and water from a fellow human being runs counter to some deep moral instincts within us. We all experience some hunger and thirst, and few sights have so immediate and powerful a negative impact as the sight of starving people. These instincts are in themselves correct, but perhaps incorrectly focused when projected upon the dying.

The terminal patient, presumably comatose or at least semi-comatose, does not experience the pangs of hunger. There is a significant difference between natural feeding of one's self or another and artificial methods—*e.g.*, IVs or nasogastric tubes. The latter are medical procedures which must be implemented by skilled persons, and this therapeutic modality makes a significant moral difference.

Nutrition and hydration must always be supplied as long as they can be received naturally. Artificial nutrition and hydration are a form of medical care analogous to the use of a respirator to sustain breathing.

There is a fine line between allowing a person to die by discontinuing extraordinary therapies on the one hand and intentionally causing death on the other. Euthanasia, which usually implies the use of some lethal means, is clearly immoral. Shortening the life of a dying person by not using procedures which merely prolong the dying process does not imply the intention to cause death. The distinction, however subtle, is a valid one. It also involves the thoroughly proper conviction that there are higher values in life than just living, in whatever state that may be. ◀

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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C.* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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2406

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Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

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CONTRAINDICATIONS – Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS – Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS – Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS – Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS – Potentiation may occur with ethyl alcohol, hypnotics, barbituates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE – Take general measures as for any CNS depressant.

SUPPLIED – TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCES:

1. Dureman I, Malmgren H, Norrman B: Comparison studies of chlorazepate [*sic*] administered as a divided daily dose and as a single dose at night. *Psychopharmacology* 57:123-126, 1978.
2. Healey M, Pickens R, Meisch R, et al: Effects of clorazepate, diazepam, lorazepam, and placebo on human memory. *J Clin Psychiatry* 44:436-439, 1983.
3. Scharf MB, Khosla N, Brocker N, et al: Differential amnestic properties of short- and long-acting benzodiazepines. *J Clin Psychiatry* 45:51-53, 1984.

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

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Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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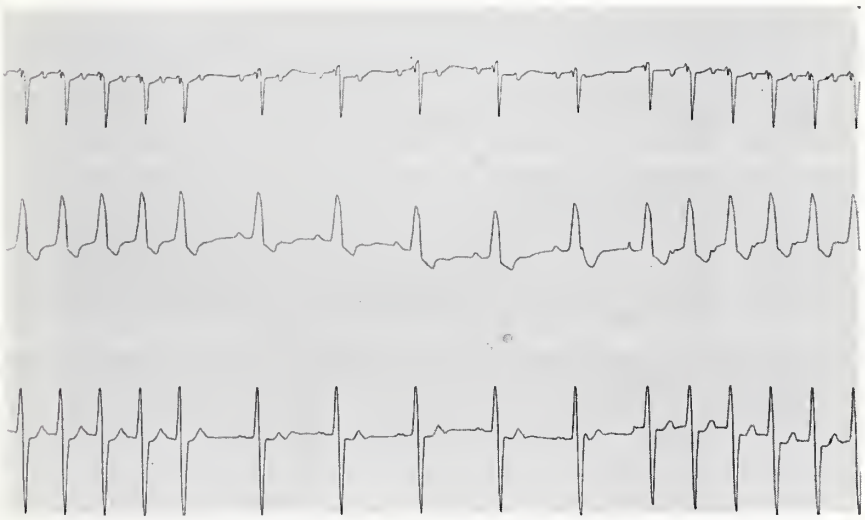
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a 72-year-old man who entered the hospital with severe dyspnea. He had a blood pressure of 120/80mmHg, distended neck veins and bilateral crepitant rales throughout both lung fields. His pulse rate was 120 beats per minute. Examination of the heart showed a diffuse point of maximum impulse that extended to the anterior axillary line. There was a loud gallop (S_3) and an accentuated pulmonary closure sound (P_2). Hepatomegaly was present. He had been hospitalized three times in recent years for severe chest pains which were caused by one myocardial infarction and two episodes of coronary insufficiency. His angina had almost disappeared over the past year, but he complained of easy fatigue. Six months prior to admission he had a Naughton protocol exercise ECG test but could only walk three minutes and twelve seconds. Radionucleotide angiography at that time showed a left ventricular ejection fraction of less than 10%. A chest X-ray now showed considerable cardiomegaly, increased pulmonary vascularity, and interstitial as well as alveolar edema. This simultaneous leads V_1, II, and V_5 rhythm strip was obtained.

Questions:

1. **The simultaneous leads V_1, II, V_5 rhythm strip shows:**
   a. Accelerated idioventricular rhythm.
   b. Bursts of non-sustained ventricular tachycardia.
   c. QRS prolongation compatible with complete left bundle branch block.
   d. Sinus rhythm with intermittent type II second degree atrioventricular (AV) block (Mobitz).
   e. An ectopic atrial tachycardia.

2. **Appropriate treatment measures for this patient could include:**
   a. Admission to the coronary care unit.
   b. Rule out myocardial infarction.
   c. Use of digoxin and diuretics.
   d. Consideration of a ventricular demand pacemaker.
   e. All of the above.

(Continued on page 350)

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C I B A

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(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
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10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

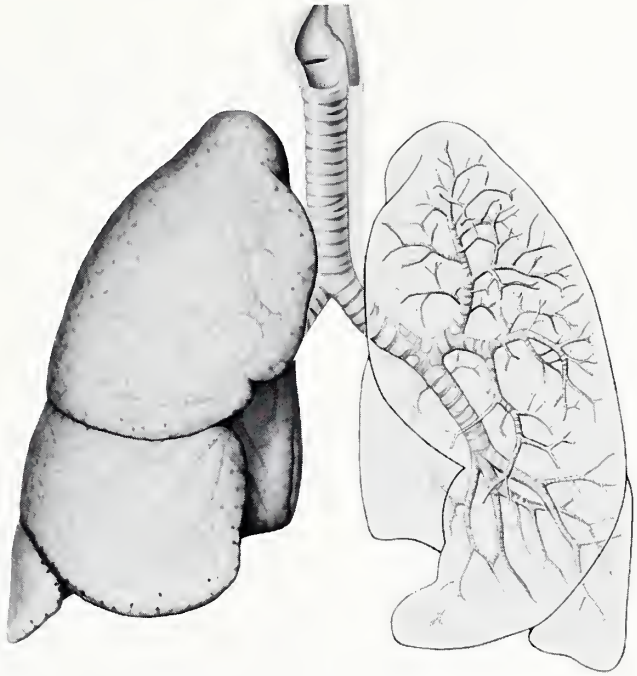
Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- Other eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

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- Slight elevations in hepatic enzymes.
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OBITUARIES

Callen, Irwin R., Chicago, died April 18, 1986 at the age of 66. Dr. Callen was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

***Connelly, John P.,** Riverside, died April 8, 1986 at the age of 59. Dr. Connelly was a 1955 graduate of the Georgetown University School of Medicine, Washington, D.C.

****Ennis, Arthur L.,** Decatur, died April 19, 1986 at the age of 80. Dr. Ennis was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

***Evans, Harvey A.,** Collinsville, died November 11, 1985 at the age of 68. Dr. Evans was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

Fisher, Josephine A. Nickless, La Jolla, California, (formerly of St. Charles) died April 3, 1986 at the age of 67. Dr. Fisher was a graduate of the University of Iowa Medical School.

Glashagel, Edward E., Elgin, died November 14, 1985 at the age of 78. Dr. Glashagel was a 1934 graduate of Northwestern University Medical School, Chicago.

****Greene, Ronald R.,** Lemon Grove, California, died April 11, 1986 at the age of 78. Dr. Greene was a 1935 graduate of Northwestern University Medical School, Chicago.

***Helberg, David S.,** Waukegan, died April 14, 1986 at the age of 53. Dr. Helberg was a 1960 graduate of the Case Western Reserve University School of Medicine, Cleveland, Ohio.

****Hipskind, Myron M.,** Oak Brook, died April 11, 1986 at the age of 77. Dr. Hipskind was a 1933 graduate of the Indiana University School of Medicine, Indianapolis.

***Kemeny, George O.,** Chicago, died January 10, 1986 at the age of 72. Dr. Kemeny was a 1937 graduate of the Lekarska Fakulta Universita Komenskebo, Bratislava, Czechoslovakia.

****Novack, Louis,** Chicago, died April 9, 1986 at the age of 83. Dr. Novack was a 1926 graduate of the University of Health Sciences/Chicago Medical School.

****O'Halloran, James J.,** East Moline, died April 19, 1986 at the age of 77. Dr. O'Halloran was a 1935 graduate of Rush Medical College, Chicago.

Ohlson, Guy E., Homewood, died January 10, 1986 at the age of 85. Dr. Ohlson was a 1925 graduate of Northwestern University Medical School, Chicago.

***Salomone, Ernest,** Canton, died November 24, 1985 at the age of 81. Dr. Salomone was a 1939 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Smith, Edwin M.,** Sun City, Arizona, died April 18, 1986 at the age of 86. Dr. Smith was a 1926 graduate of Northwestern University Medical School, Chicago.

Terrefe, Dessalegn, Centralia, died September 20, 1985 at the age of 47. Dr. Terrefe was a 1965 graduate of the School of Medicine, American University of Beirut, Lebanon.

****Tratt, Elliott M.,** Morris, died April 22, 1986 at the age of 76. Dr. Tratt was a 1936 graduate of Northwestern University Medical School, Chicago.

***Urban, Rudolf J.,** Pekin, died April 17, 1986 at the age of 61. Dr. Urban was a 1950 graduate of Orvosi Fakultas Tudomanyegyetem, Budapest, Hungary.

Wilson, Clyde S., Belleville, died April 7, 1986 at the age of 101. Dr. Wilson was a 1910 graduate of Illinois Medical College, Chicago.

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J-6138 January 1986

Splitting Hairs

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

It can be difficult to find a suitable conversational venue in mid-afternoon. The 10 o'clock coffee roundtable is perfect in the morning, but after breakfast, mid-morning coffee, and lunch, he who is in search of conversational stimulation, (that's me) needs a place with less caffeine and minimal calories.

Frank's Clipping Post fits the bill. There the sitters, watchers and readers can fearlessly engage in argument or conversation. The only one at risk is the jasper in the chair. Recall once when Otis Landsworth nodded vigorously at something Frank said. Caused the clippers to move quickly right up the back of his neck and head to mid-crown. If this was one of those trendy places, Otis' "reverse mohawk" would have started a whole new thing. As it was, he just stayed tight to his baseball cap all summer.

Well, on this particular occasion Doc Frank was in the chair limiting his responses to gutteral tones as barbering Frank became impressively surgical, reassuring all that he carefully sterilized his instrument between each customer. He then hastened to add—not wanting to cast aspersions on our doctor—that present company excepted, one never knew when he might be exposed to the hair of an AIDS patient, and he absolutely wanted to be safe, and wanted his customers to be safe as well.

Doc Frank was at the brushing and fluffing stage then, and felt safe to respond, "That's not the way AIDS is transmitted," and went on to a simple explanation of that. "Then how come some doctors, nurses and EMTs are refusing to give CPR and mouth to mouth resuscitation to AIDS people?" asked Chic. Lonnie added his bit too, by asking about the kids that have been kept out of school because of it.

The doctor responded rather sadly to those queries—not so much to the school folks keeping kids with AIDS away from school-after all, they aren't professionals and aren't as aware of the scientific facts. Doctors, nurses and others, however, who refuse care, Doc had no tolerance for!!

"When those of us who have decided on a career of caring and giving, back off because of a risk—particularly when that risk is minimal—and that's the case here . . . . well that's awful!" said Doc.

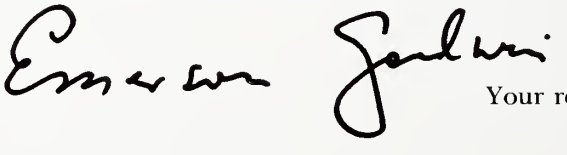
"Before my time, before antibiotics and such, the infections—typhoid fever, plague, and cholera—were lethal conditions. There was no treatment at all except to try to keep the patients comfortable. Doctors and nurses did what they could to alleviate the symptoms—didn't refuse care because of their own risk. Polio is one that I can remember. People died and were crippled. Lost two of my classmates in my internship and none of us refused to do what little we could."

"All in all, it burns my soul to hear about doctors and nurses who should know better, well . . . ."

Lonnie reflected as Doc went out into the street, "I remember the polio epidemics too—terrible!!"

"Yep", said Frank, putting his shears into the sterilizing jar, "don't remember worrying about catching that from one haircut to the next."

For my part, I agree with Doc. For those of us who cut hair, or pump gas,—we really do not know better. And although I don't want to split hairs, you doctors do know better, and you should set the scientifically correct example for public behavior. I'm sure that will be the way it is. ◀



Your respectful servant,
E. Goodwin

Final Task Force Report

Medical Discipline Moves Forward

Illinois Governor James R. Thompson appointed a Medical Malpractice Task Force in November, 1984, to study issues which arose in the quest for legislative reform. Their final report defined many of the tenets of the medical malpractice legislation signed into law in August, 1985. The 1985 Medical Malpractice Task Force report suggested that both the legal and medical professions should work to improve professional discipline. ISMS cooperated with the Governor in forming a Task Force on Medical Discipline, chaired by Alfred J. Clementi, M.D. This task force presented its report to the Governor, who endorsed it at a May 19 press conference and called upon the Illinois General Assembly to pass appropriate legislation.

Concrete progress in medical discipline reform took shape last month when the Governor's Task Force on Medical Discipline issued its final report containing 20 legislative recommendations.

"In April of 1985, the Medical Malpractice Task Force called for improved efforts by the legal and medical professions in policing themselves," the Governor said. "The medical community has answered that call. Now, the legal community must come forward to do the same."

Governor Thompson characterized the report as a major step forward. "Patients in Illinois must have a better way to complain against offending doctors and doctors must have a better way to discipline offenders," he told the group. "The sweeping changes recommended in the task force report go straight to the heart of the problems doctors have experienced in attempting to seriously discipline members of their own profession."

The Governor touched on inadequacies in the present disciplinary system. "The task force has done an outstanding job of addressing these procedural and philosophical problems," he said. "Through new legislation and regulatory changes in the Department of Registration and Education, the medical community will be more involved in the disciplining process and the state will have at its disposal expanded and more clearly defined grounds for discipline."

Chairman Alfred J. Clementi, M.D., summarized the task force findings (*see box*). Alfred J. Kiessel, M.D., chairman, ISMS Board of Trustees, and Allan L. Goslin, M.D., ISMS president-elect, joined Dr. Clementi in presenting the report, as did Gary Clayton, director of the Illinois Department of Registration and Education and Jeffrey Miller, director of planning for the Governor's office.

Dr. Clementi identified two key needs: a means to streamline and strengthen the disciplinary process and a mechanism for physician and hospital input in identifying and weeding out incompetent practitioners.

"First, to strengthen the process itself, we have recommended lengthening the time frame for the state to discipline doctors," he said. "Often, complaints based on criminal or legal actions cannot be pursued by disciplinary authorities within the current three-year limit from the time of the incident." The task force report calls for a three-year limit from receipt of the complaint rather than from the time of the incident. This may amount to up to five years from the date of the alleged incident.

In another recommendation designed to strengthen the disciplinary process, the task force recommended that state authorities be given expanded access to medical records. "They should also be granted authority to inspect a physician's office for good cause," Dr. Clementi told the group. "And they should be allowed to move more quickly against physicians under investigation by other state agencies, such as the Illinois Department of Public Aid."

Cooperation is a key theme of the report. The task force calls for investigation of physicians who have been disciplined elsewhere even before a formal complaint has been filed in Illinois.

(continued on page 348)

An Historical Perspective

ISMS President-Elect Allan L. Goslin, M.D., Streator, and ISMS Board of Trustees Chairman Alfred J. Kiessel, M.D., Decatur, joined Dr. Clementi in presenting the task force report to the Governor. Dr. Goslin's comments are reproduced below.

The Illinois State Medical Society enthusiastically supports the efforts of Governor James R. Thompson and the Task Force on Medical Discipline to identify and discipline physicians who should not be practicing medicine.

The 16,000 physician members of the Illinois State Medical Society have consistently supported strong measures to prevent bad doctors from any patient contact. The Governor's proposals will give us an opportunity to play a meaningful, active, aggressive and substantive role in the state-regulated disciplinary process.

We have a long record of proposing and supporting legislation to improve discipline. We supported creation of the Medical Disciplinary Board and increases in licensure fees to fund its efforts. More recently, we supported mandatory reporting that requires organizations to report doctors who may be practicing bad medicine. These reports include physicians who have paid damages in a malpractice suit, have had their hospital privileges restricted or terminated, have been sanctioned by a medical society or have been found guilty of breaking a state or federal law. We now welcome the opportunity for a more direct, active role in this process.

We have asked the Illinois Department of Registration and Education to allow us to help. Specifically, they have been asked to identify physicians believed to be practicing medicine inappropriately so that deputized physician reviewers can recommend appropriate disciplinary action.

Last year, we made proposals for malpractice reform and the Illinois General Assembly agreed to some of our proposed reforms. We will return next year for the rest of our proposals because we do not believe reform is complete and the reforms we did pass await a Supreme Court decision.

The Governor's Task Force on Medical Malpractice called for many of the reforms that passed and asked the medical profession to improve medical discipline. We took this request to heart. We joined the Governor's Task Force on Medical Discipline and developed recommendations, which, if passed, will produce a model state medical disciplinary process. If enacted our disciplinary board will be second to none.

The Illinois State Medical Society supports the rights of physicians to provide the best medical care possible and the rights of patients to seek care with confidence, from any physician.

The system of preventing bad doctors from providing patient care should be as nearly perfect as we can make it. All good doctors benefit from a vigorous disciplinary system to weed out bad doctors.

In some cases, the physician is impaired. The medical society has a program that can help identify and treat impaired physicians. The goal of the program is to protect patients from harm and return the physician to good health and good medical practices. Doctors who are beyond or refuse assistance should not be allowed to practice.

The medical society wants every patient to be treated with concern, care and competence. The outcome of care may not be what the patient or the doctor hoped for. But we should work toward the best possible courses of diagnosis and treatment.

Some people have used the number and disposition of malpractice suits as an indication that a physician is practicing bad medicine. The medical community does not deny that actual malpractice occurs. It does deny the linking of poor medical care to malpractice suits.

We want to get rid of bad doctors. We want legislation that gives the state and its physicians the right to prevent any bad doctor from caring for any patient. We want to be able to do that without fear of reprisal. We want the tools to improve the quality of patient care for all Illinois citizens. We think the Governor's legislation is a giant step toward getting rid of bad doctors. We applaud and endorse his effort and reaffirm our commitment to him to make it work. ◀

Task Force Recommendations

The Task Force on Medical Discipline recommended twenty specific reforms in the state's medical discipline system. These included eleven statutory, three regulatory and six administrative recommendations.

1. *Lengthen the time frame for disciplinary investigation and action.* A three year limit from commission of the alleged act or complaint to final Board action is too short. Many cases, especially those stemming from other legal and criminal actions, cannot be fully investigated within this limit. The Task Force recommends that the Medical Disciplinary Board instead be afforded three years from the time an actionable item is *received,* and up to five years from the date of the incident. Further, the Board should have 180 days for initial investigation of mandatory reports.

2. *Allow access to medical records of public and private patients* treated by those under disciplinary investigation. This can be accomplished without compromising confidentiality of information or patient identity.
3. *Establish and deputize review panels,* to assist in the review of alleged violations brought before the Medical Disciplinary Board.
4. *Involve professional organizations in the review of excessive fees* or other activities of those licensed under the Medical Practice Act.
5. *Grant immunity to organizations,* such as county medical societies, *which participate in fee review functions,* and discuss the appropriateness of physician fees.
6. *Modify the Hospital Licensing Act* to oblige hospitals to aggressively search out any previous action which may have been taken against a physician's license. This could be accomplished through a mandatory contact by the hospital to the Department of Registration and Education.
7. *Require automatic review of impaired physicians* under state monitoring who remove themselves from therapy programs.
8. *Grant the Medical Disciplinary Board authority* to order inspection of a physician's office.
9. *Expedite Medical Disciplinary Board review of allegations brought by other state agencies* and professional organizations against those licensed under the Medical Practice Act.
10. *Re-define gross malpractice* for clearer understanding and application.
11. *Strengthen and clarify the grounds for discipline* to coincide with those in the model Medical Practice Act of the Federation of State Medical Boards.
12. *Allow the Medical Disciplinary Board to share information on impaired physicians with hospital medical staffs.* Upon request, the Board could release information on an impaired physician's "reported" status, for confidential use in the credentialing process.
13. *Establish a special physician board of clinical examiners* to verify clinical competence on behalf of the Medical Disciplinary Board. This panel should work in coordination with the Medical Practice Examining Committee to develop specific examinations.
14. *Create a new set of disciplines,* such as fines, to penalize practitioners for inappropriate, continuing business practices. These remedies are appropriate for situations which inconvenience but do not harm patients. Financial penalties are inappropriate when injury is involved.
15. *Organize two medical coordinator posts,* one in Springfield and one in Chicago, to provide for a medical coordinator and a deputy medical coordinator.
16. *Develop a roster of physician experts* (by specialty) available to both medical coordinators for screening, reporting on and testifying to complaints.
17. *Improve coordination with other state and national agencies* on disciplinary actions taken against individuals; improve coordination with other Illinois state agencies; strive for uniform reporting of disciplinary actions between states.
18. *Foster independent, proactive investigation by the Medical Disciplinary Board* and the Department of Registration and Education, even in the absence of formal complaints. This must be done carefully, in keeping with current statutory authority.
19. *Improve communications* between state authorities, the medical profession and the public, on the role and process of medical discipline in Illinois.
20. *Assure competent Medical Disciplinary Board investigators,* by increasing training and compensation. ◂

Medical Discipline

(continued from page 345)

Dr. Clementi added that, under the task force recommendations, hospitals would be required to research credentials of physicians applying for privileges, including any previous disciplinary action in another state. Modifications in the Hospital Licensing Act were proposed for this purpose.

Overall restructuring of the grounds for discipline is another concern. "We recommend strengthening the definition of gross malpractice and the grounds for discipline in Illinois," Dr. Clementi said. "We would create a whole new set of disciplines. And we would establish fines for improper practices not harmful to patient health."

Impaired physicians were also the subject of task force study. It was recommended that the Medical Disciplinary Board advise hospital medical staffs when impaired physicians are placed under supervision. Under the task force recommendations, impaired doctors who leave treatment programs would automatically come before the disciplinary board for review.

Deputized review panels are a major component of the task force report. Dr. Clementi explained that the panels would provide for daily, hands-on input by the medical profession in rooting out bad practitioners. The task force recommendations would grant significant authority to the deputized panels. "Under direct supervision of the Medical Disciplinary Board," he said, "these panels would assist in review of alleged violations and recommend discipline to state authorities."

Dr. Clementi characterized controversy over excessive fees as the greatest source of patient-physician misunderstanding. "We also recommend that private professional medical societies be granted authority, with state oversight, to adjudicate fees," Dr. Clementi said. "Many, many patient complaints on the cost of medical services now come to these organizations every day. But under the current system, little can be done to resolve the problems, due to antitrust and anticompetitive concerns." Dr. Clementi emphasized that it was imperative to guarantee appropriate quality of care protections for patients. His comments underscored the importance of protecting patients from pressures by third parties seeking to place economic criteria before quality concerns.

The task force called for creation of a special physician board of clinical examiners to investigate clinical competence and a roster of physician specialists to screen, report and testify on complaints. In another measure designed to enhance resources available to disciplinary authorities, the task force called for a deputy medical coordinator's post to assist the state's chief enforcement officer.

Dr. Clementi closed his comments with a call for perspective and vigilance. "Some have attempted to equate the rise in medical malpractice suits with lax discipline here," he said. "The task force found no substantiation for this theory. Medical malpractice suits are all too often the burden of excellent, high-risk doctors, handling tough cases. But in those few instances where gross malpractice indicates incompetence, we are determined to find and penalize those physicians."

The Governor announced that the task force recommendations had been embodied in Senate Bill 2202, sponsored by Senators Judy Barr Topinka, Riverside, Jack Schaffer, Crystal Lake and John Davidson, Springfield.

Members of the task force included representatives of the physician leadership as well as responsible state regulators. In addition to Dr. Clementi, immediate past chairman of the ISMS Board of Trustees, physician members included Harold L. Jensen, M.D., Chicago Medical Society president; David S. Fox, M.D., chairman, Illinois Department of Registration and Education Medical Practice Examining Committee; Morgan M. Meyer, M.D., 1985-86 ISMS president and Risher Watts, Jr., M.D., chairman, Illinois Department of Registration and Education Medical Disciplinary Board. State officials who served on the task force were Gary Clayton, director of the Department of Registration and Education; Thomas Killala, chief of medical investigations for that department and Jeffrey Miller, director of planning for the Governor's office. ◀

Staying Alert to Side Effects

Two articles presented in this issue deal with problems arising when we use chemotherapy to treat malignancy and for immunosuppressed patients. These problems also arise when drugs are utilized for a specific purpose, as illustrated by use of cimetidine to cut down gastric acid secretion.

It is evident that the human organism is a combination of checks and balances. When we upset the balance—as when we cut down the gastric acid by drugs or gastric resection as illustrated in the article, "Primary and Secondary *Candida* Esophagitis in Normal, Healthy, Subjects"—we set the stage for overgrowth of *Candida. Candida* are commonly present in the GI tract of normal individuals in small numbers, and only become a problem when the usual environment is changed. Similarly, our bodies' immune defenses will control viral and/or yeast infection until such time as they are suppressed, as illustrated in "Herpes Simplex and *Candida* Esophagitis."

In the two reports in this issue, we have excellent examples of what well-intentioned therapy can accomplish in a negative direction. Let us always be alert to possible side effects of our therapy.

Eli L. Borkon, M.D., Carbondale
Member
IMJ Editorial Board

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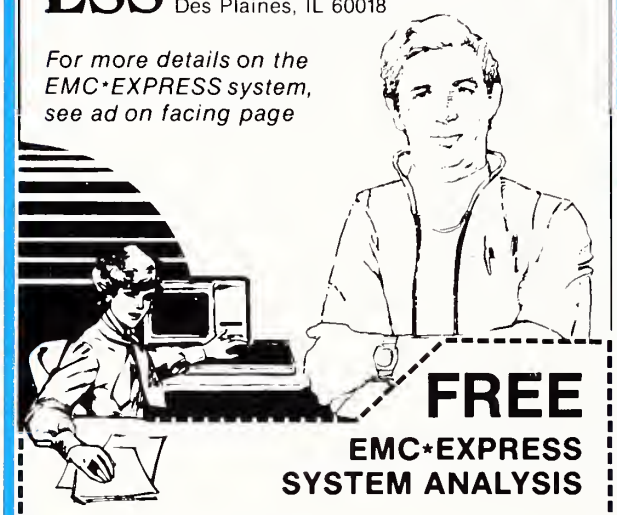
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(Continued from page 335)

Answers: 1. C. D. 2. E.

The simultaneous leads V_1, II, V_5 rhythm strip shows sinus rhythm at a rate of 120 beats per minute. The PR interval of the beats is prolonged to 0.22 seconds and the QRS duration is prolonged to 0.14 seconds. The sinus conducts to the ventricles on a one-to-one basis with a consistent PR interval in the first five beats of the strip. Then sinus with two-to-one AV block develops for the next five beats and reverts to one-to-one conduction for the last six beats. There is no change in the PR interval of the conducted beats before or after the dropped sinus beats. This is type II second degree AV block or a Mobitz block.

A twelve lead ECG confirmed the fact that the prolonged QRS, best seen in the middle strip lead II, was caused by complete left bundle branch block. A type II second degree AV block is usually associated with His-Purkinje system disease. There is evidence for bundle branch disease in the presence of complete left bundle branch block. The deep negative component of the P wave in lead V_1 (top strip) is caused by left atrial enlargement. Simultaneously recorded leads make it easier to see the P waves.

The presence of these ECG findings makes the diagnosis of acute myocardial infarction on the ECG difficult. On the other hand, his clinical presentation suggests that some catastrophic event had occurred. In the coronary care unit a myocardial infarction was suggested by serial serum enzyme determinations. Digoxin and diuretics as well as oxygen by nasal cannula were administered. The presence of type II second degree AV block and complete left bundle branch block suggest bilateral bundle branch disease.

In the setting of acute infarction, a temporary pacemaker ought to be considered because of the increased incidence of complete heart block. However, heart block did not occur in our patient. Instead, he developed ventricular fibrillation on the second day. Endotracheal intubation and a dopamine infusion were required to manage his myocardial infarction and heart failure. ◀

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Seventy Cases

Surgical Approach to Acoustic Schwannomas

By Richard J. Wiet, M.D., Robert P. Kazan, M.D., Sharon Pircon, M.S. and Stevenjames Meikle, L.P.N./Hinsdale

Earlier diagnosis and closer cooperation with allied specialists in neurosurgery have lessened complications of acoustic tumor surgery. Facial paralysis or its sequellae remain the most frequent complications of this procedure. Such complications cannot always be prevented. Selection of the best approach for acoustic tumor extirpation is subject to continuing controversy. Each team must answer this question themselves; our experience favors the transtemporal approach. This approach gives a more accurate anatomical definition of the facial nerve. Efforts to preserve hearing (especially when excising tumors 2.0cm or larger), may prove futile. They may also increase the risk of facial paralysis in some cases.

This case might also remind physicians that environmental assault is not the sole cause of hearing loss.

Complications of acoustic tumor removal and selection of a surgical approach with minimal morbidity and mortality are the subjects of this report. Eighty patients with acoustic tumors were referred over a five year period; 70 underwent surgery. The same neurotologic-neurosurgical team recommended a one-stage procedure in each case. The first 10 cases were done via the suboccipital (upright) approach. The remainder have utilized a transtemporal approach (60 cases).

The objectives of acoustic tumor surgery (in order of importance) are: (1) total tumor removal without death or major morbidity, (2) preservation of facial nerve function, and (3) preservation of hearing if possible. Gains have been made in all three areas, but the nature and size of the tumor often preclude total success.

An increasing number of otologic surgeons use the upright, suboccipital transmeatal approach. Various advantages of this method have been described.[1-4] In his classic 1964 monograph[5] House called for cooperation between otologists and neurosurgeons. Our Chicago skull base team was developed on this model. We first chose the upright suboccipital approach because of the neurosurgeon's initial unfamiliarity with transtemporal techniques. Since our first 10 suboccipital cases, we have converted almost exclusively to the transtemporal technique. While this paper is not intended to diminish in any way those surgeons who favor the posterior approach, it does stand as a record of our experience.

Materials and Methods

Eighty patients were referred for surgical extirpation of acoustic tumors over a five-year period. All procedures were completed in *one stage,* including those involving 5.5cm (large) tumors. Patient age ranged from 26 to 80 years. Most patients were in the fifth decade. There were 37 females and 33 males.

Tumors were sized in three groups. Small tumors were those 1.5cm or less, medium 1.5cm to 2.9cm, and large, 3.0cm or greater. In this series 19 were large, 35 were medium, and 16 were small. Most tumors were schwannomas of the

eighth cranial nerve. There were four meningiomas and one lipoma. All but six patients underwent total tumor removal. Four tumors were not removed due to early inexperience. Two were intentionally left in place due to operative conditions or patient age.

Most patients in this series had unilateral hearing loss with diminished discrimination; 11 patients had speech reception thresholds (SRTs) less than 24dB before surgery and six patients (8.6%) had discrimination scores greater than 90%. Indeed, two patients had normal hearing preoperatively, which underscores the variability of auditory presentations in patients with acoustic tumors.[6] A final diagnosis of patients with acoustic tumors was made by CT scan in 56/60 patients and by pneumocisternography in four. The size was determined in the anterior posterior transverse (axial) and vertical (coronal) diameter. The greatest extracanalicular diameter was recorded with the aid of the computer.

Patients were intraoperatively monitored with an evoked response of the auditory nerve when a suboccipital approach was used and hearing preservation was sought. The equipment settings were: filters 100-3000Hz, amplification 200,000X, and latency window 10 msec. The stimulus duration used was microseconds, with decibel loudness for intraoperative monitoring at 102.

Surgery was not performed in 10 cases. Three patients were elderly with small tumors, five deferred surgery, and two had medical illness which precluded surgery.

Chart review and questionnaires were used for retrospective caseload evaluation. Complications were recorded as intraoperative, postoperative, and late, and were correlated with tumor size.

Table 1
Comparison of Surgical Approaches with Regard To Hearing Preservation and Difference in Tumor Size (n = 70)

Surgical Approach	Number of Patients	%	Tumor Size*	Number of Patients	%	Number of Patients in Whom Hearing Saved	%
Suboccipital	10	14.29	Large	5	50	0	0
			Medium	4	40		
			Small	1	10		
Retrosigmoid	2	2.9	Large	0	0		
			Medium	2	100	2	100
			Small	0	0		
Middle Fossa	6	8.6	Large	0	0		
			Medium	1	16.7	3	50
			Small	5	83.3	(small)	
Total						5/70	7

**Large: ≥3 cm; Medium: 1.5-2.9; Small: <1.5 cm*

Results of Surgical Approaches

The translabyrinthine approach was used in 33 cases. The combined translabyrinthine-suboccipital was done in 17, the suboccipital was done in 10, the middle fossa in seven, and the retrosigmoid in three. Each approach was assessed on the basis of mortality, intraoperative complications, facial nerve preservation, complete or incomplete removal of tumor, and hearing preservation.

Suboccipital Cases

In a series of 10 suboccipital cases, there was one death, presumably due to a pontine infarction. The remaining nine patients survived the operation. One patient required emergency surgery for a cerebellar hematoma after the initial procedure. The lateral third of the cerebellum was resected and the patient appeared to have a persis-

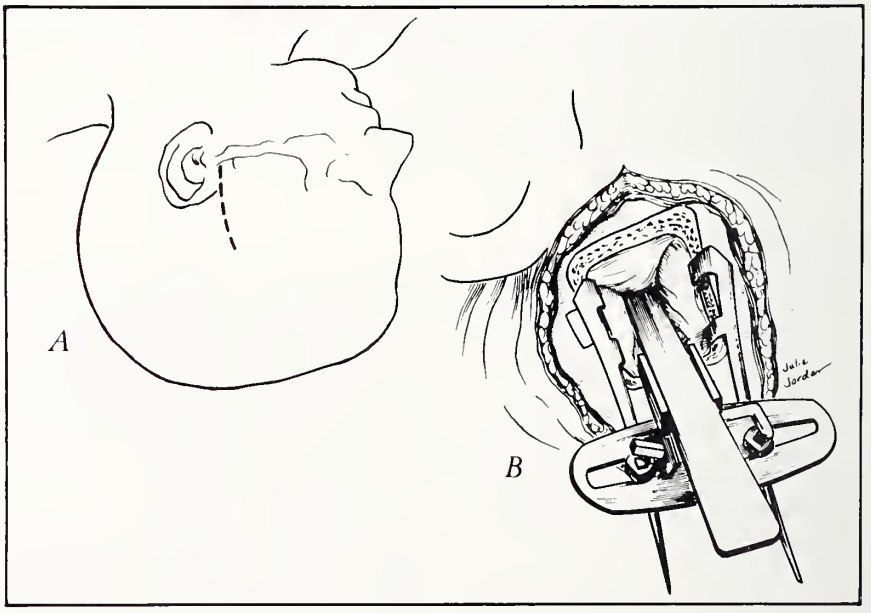


Figure 1.
Middle fossa approach to the CP angle. The authors successfully preserved hearing in 3/6 cases. There is a slightly higher risk to the facial nerve with this approach.

tent ataxic disability. None of these patients had persistent cerebrospinal fluid (CSF) leak or meningitis. Facial nerve grafting through the posterior approach was required in four of 10 cases. Hearing was not preserved in any of the 10 procedures performed suboccipitally, despite intraoperative brainstem recordings in 7/10 cases (Table 1). All patients in this series (except one elderly individual) had complete tumor removal.

Transtemporal Cases

Hearing Preservation (middle fossa and retrosigmoid, 10 cases)—

In the middle fossa operations, three of six patients (Figure 1) had useful hearing. We were also able to preserve hearing in two patients with the retrosigmoid approach. Complications in this series of patients were uncommon, but two patients suffered prolonged facial paresis (one with poor recovery). There were no deaths, CSF leaks or other serious complications.

Translabyrinthine and Combined Translabyrinthine-Suboccipital Approach (Figure 2)—

Traditionally, the translabyrinthine approach has been complicated by a high rate of CSF leak and by meningitis.[7] M.E. Glasscock noted in 1979 personal conversation that, because of technical improvements, only two of 70, (3%) had transient CSF leaks and one (1.4%) developed meningitis. There were no deaths and no posterior fossa hemorrhages. The facial nerve was kept intact in 90%. However, 50% of patients had some degree of dysfunction, either immediate or delayed (Table 2). Facial nerve preservation rate was slightly better with the translabyrinthine approach than the combined approach. Facial nerve preservation correlated to tumor size; small and medium tumors showed the greatest rate of preservation. Most patients with facial palsy improved over time. Gradual improvement continued for up to 15 months. Rare complications which were recorded were otic hydrocephalus, inappropriate ADH syndrome (2), and transient hemiparesis (1). We were unable to remove all tumor in six patients due either to operative conditions or early inexperience.

Table 2.
Surgical Complications in Acoustic Tumor Removal (70 Patients)

Operative Complications	Number of Patients	%
Facial Nerve Dysfunction or Paresis (temporary)	35	50
Facial Nerve Grafts	6	8.6
Cerebellum (Ataxia)	1	1.4
Fifth Cranial Nerve	0	0
Anterior Inferior Cerebellar Artery (Death)	1	1.4
Lower Cranial Nerves (9-12)	0	0
Hemiparesis	1	1.4
Otic Hydrocephalus	1	1.4

Discussion

It is important to maintain appropriate priorities in discussing the results of acoustic tumor surgery. Patient safety and minimal morbidity and mortality are paramount concerns. Cases were not chosen at random, and any comparisons must be made with caution. However, a trend or preference toward a transtemporal approach has become apparent. Perhaps it is most appropriate to compare surgical approaches.

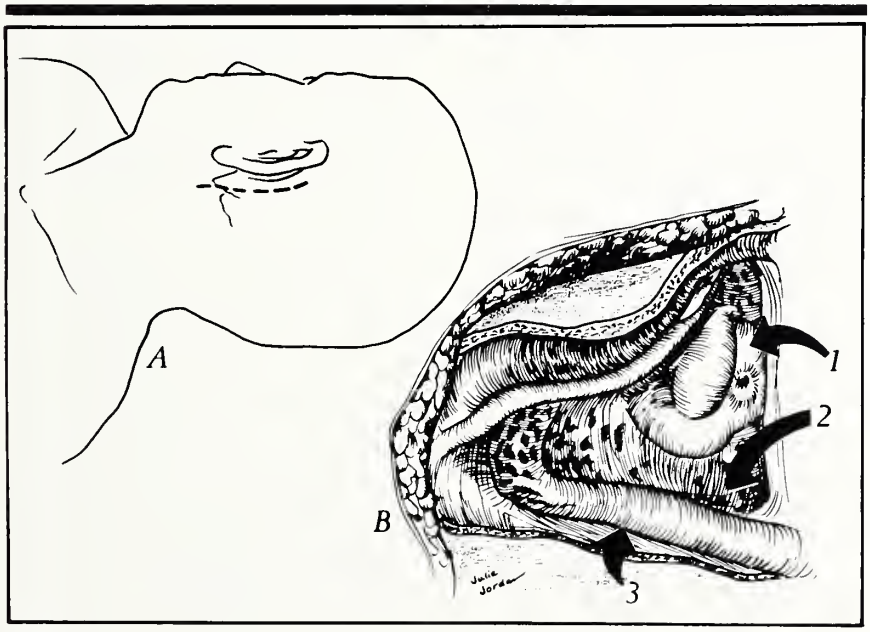


Figure 2.
Transtemporal approach to the CP angle. A retrosigmoid approach (3) has successfully preserved hearing in two patients with extracanalicular meningiomas. By combining 1 and 3, large tumors are approached on both sides of the sigmoid sinus.

Suboccipital Approach

Surgeons have stated that the suboccipital approach requires less time in surgery, causes less CSF leakage and subsequent meningitis, and enhances the ability to preserve hearing. We have enjoyed a rather low rate of CSF leaks (3%) and, with increasing experience, our operative time has diminished. We were unable to preserve hearing in our series of suboccipital exposures and lost four facial nerves in a series of 10 cases. It should be noted that the majority of tumors in this series of cases were 2.0cm or greater.

Middle Fossa Approach

We found few complications with the middle fossa approach, designed to preserve hearing. Tumors here were generally small. A disad-

vantage of the middle fossa approach, however, was prolonged facial paralysis in two patients with slightly extracanalicular tumors. We did preserve hearing in the three cases involving the retrosigmoid approach (supine position). This was probably due to the fact that both were extracanalicular meningiomas.

Translabyrinthine or Combined Suboccipital-Translabyrinthine Approach

We preserved the facial nerve in the majority of cases in the translabyrinthine series or combined suboccipital-translabyrinthine series. However, despite anatomical preservation, function had been affected to some degree in nearly 50%. Gradual improvement occurred in the majority.

The problem of hearing loss with the translabyrinthine approach is addressed in a number of ways. Most of our patients had SRTs of less than 50dB with discrimination scores of less than 50%. Studies by Neely[8] have shown tumor involvement of the cochlear nerve as tumors approach the brainstem. His histological data show that complete resection from VIII nerve (cochlear) fibers may be beyond our present technological capabilities. As also pointed out by Clemis,[9] it may be difficult to identify candidates for conservation surgery. Additionally, it is easy to damage the labyrinth from a suboccipital exposure.[10] Other authors have suggested that the horizontal crest may be used as a safe landmark to avoid labyrinthine injury. However, Domb and Chole have shown through their dissections that labyrinthine injury easily would occur with this as a sole landmark. Finally, preservation of hearing seems to be directly related to two factors: preserving the cochlear nerve and maintaining its blood supply.

The majority of tumors in this series were medium to small lesions that occurred in people in their fifth decade. Tumors of this size are readily accessible transtemporally with the patient supine. The likelihood of air embolism and the remote possibility of quadriplegia are lessened when the patient is supine.[11]

Conclusions

Our initial experience in acoustic neuroma surgery has been similar to that of several otologists who regularly perform this type of surgery.[12-14] In each instance, experience with suboccipital exposure has given way to the transtemporal. The transtemporal or translabyrinthine method has proved satisfactory for total removal of acoustic tumors of all sizes with low morbidity and mortality. Facial nerve preservation rates in cases involving small and medium tumors are satisfactory; this percentage falls with large tumors. ◀

References

1. Palva, T.: "The Relevance of Experimental Otology to Clinical Work. Original Article, 1073," *J Laryngol Otol* 1984.
2. Shea, M.C., Robertson, J.T.: "Acoustic Neuroma Removal: A Comparative Study of the Translabyrinthine and Suboccipital Approaches," *Amer J Otol* 1:2, 1979.
3. Geurkink, N.: "Surgical Anatomy of the Temporal Bone Posterior to the Internal Auditory Canal: An Operative Approach," *Laryngoscope* 87:975-986, 1977.
4. Harner, S.C., Laws, E.R.: "Posterior Fossa Approach for Removal of Acoustic Neuromas," *Arch Otolaryngol* 107:590-593, 1981.
5. House, W.F.: "Transtemporal Bone Microsurgical Removal of Acoustic Neuromas," *Arch Otolaryngol* 80:599-676, 1974.
6. House, W.F.: Acoustic Tumors Baltimore, University Park Press, 1979.
7. Glasscock, M.E., Hays, J.W.W.: "The Translabyrinthine Removal of Acoustic and Other Cerebellopontine Angle Tumors," *Ann Otol* 82:415, 1973.
8. Neely, J.G.: "Is It Possible to Totally Resect an Acoustic Tumor and Conserve Hearing?" *Otolaryngol Head Neck Surg* 92:162-167, 1984.
9. Clemis, J.D., Mastricola, P.E., *et al.*: "The Contralateral Ear in Acoustic Tumors and Hearing Conservation," *Laryngoscope* 91:1792-1800, 1981.
10. Domb, G.H., Chole, R.A.: "Anatomical Studies of the Posterior Petrous Apex with Regard to Hearing Preservation in Acoustic Neuroma Removal," *Laryngoscope* 90 (11):1769-1776, 1980.
11. Hitselberger, W.E., House, W.F.: "Warning to the Otolaryngologist About the Sitting Position," *Arch Otolaryngol* 106:69, 1980.
12. Sterkers, O.: *Acta Otolaryngol,* 99: 1985, to be published.
13. King, T.T., Morrison, A.W.: "Translabyrinthine and Transtentorial Removal of Acoustic Nerve Tumors," *J Neurosurg* 52:210-216, 1980.
14. Tos, M., Thomsen, J.: "Preservation and Reconstruction of Facial Nerve After Translabyrinthine Removal of 200 Acoustic Tumors," *Adv Oto Rhino Laryngology* 34:176-186, 1984.

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In Normal, Healthy Subjects

Primary and Secondary *Candida* Esophagitis

By Kamthorn Phaosawasdi, M.D., Pamela Rice, R.N. and Bak Lee, M.D./Bloomington

We report four normal, healthy individuals who exhibited esophageal Candida *infection. Three of these individuals had decreased gastric acid output. Two of them were on prolonged treatment with cimetidine, while one had undergone a subtotal gastrectomy. We suspect that decreased gastric acid output may be one of the major factors in the candidiasis of these three patients. Therefore, we caution prolonged treatment with cimetidine.* Candida *infection should be suspected in any patient who has been using cimetidine for a long period of time and displays symptoms of esophagitis.*

Candida infection in the esophagus is a common occurrence in immunocompromised individuals, and persons with certain endocrine disorders. These endocrine disorders include hypothyroidism, hypoparathyroidism, hypocorticism, and diabetes mellitus.[1] Immunosuppressed individuals include organ transplant patients receiving immunosuppressive therapy, neoplasia, and more recently, AIDS victims. Severely depressed cell-mediated immunity is responsible for the increased proliferation of *Candida*.[2] The most common presenting complaint is odynophagia, with or without dysphagia, as well as retrosternal pain and bleeding.[3] It is important to recognize that candidiasis can occur in apparently normal individuals.[4] Typically, candidiasis presents with a white cheesy plaque. However, severe reflux esophagitis may hinder its recognition. *Candida* infection in the esophagus can involve grave consequences if complications are allowed to develop. Complications can result in death, as illustrated in the case of tracheoesophageal fistula reported by Obrecht, *et al.*[5]

Individuals who exhibit *Candida* infection in the esophagus as the primary entity rather than as an infection which is possibly secondary to other local pathology, are of particular interest. Gastric acid can protect against *Candida* in normal individuals; involvement usually seems to cease just short of the esophagogastric junction due to acid reflux.[6] We have had experience with four apparently normal individuals exhibiting candidiasis of the esophagus. Three had primary esophageal candidiasis, while in the fourth, candidiasis may have been a secondary infection. Three of the four shared a common factor, decreased gastric acid secretion. Decreased secretion was seen in two patients due to medications, and in one due to a subtotal gastrectomy. The fourth was using sodium bicarbonate. (Table 1) However, we could not determine how much this lowered the gastric acid secretion. Does the esophageal environment become conducive to *Candida* infection when gastric acid secretion becomes less than normal?

Case One

A 39-year-old white female presented with five days' left-sided abdominal pain, severe diarrhea, and anorexia. She had experienced similar symptoms in previous years. Irritable bowel syndrome had been diagnosed. Medical history included migraine headache, gastric and duodenal ulcer, and anemia. Surgical history consisted of total abdominal hysterectomy with right-sided salpingoophorectomy for cervical cancer eight years before.

At the time of admission, the only medications she was taking were lorazepam and dicyclomine hydrochloride. She had used cimetidine within the previous year for peptic ulcer disease. Evaluation included abdominal sonography, electrocardiogram, chest x-ray, complete blood count, chemistry profile, quantitative immunoglobulins, and serum gastrin. Each of these studies was found to be normal. Skin testing for cellular immunity was positive for mumps and PPD.

On the third hospital day, she

Table I
ESOPHAGEAL CANDIDIASIS—FOUR NORMAL, HEALTHY SUBJECTS

NO.	AGE	SEX	WHITE ESOPHAGEAL PLAQUES	ASSOCIATED ESOPHAGEAL PATHOLOGY	GASTRODUODENAL PATHOLOGY	SYMPTOMS ATTRIBUTED TO CANDIDIASIS	PREVIOUS MEDICAL CONDITIONS	ANTIBIOTICS, IMMUNOSUPPRESSIVES OR ANTI-ACID MEDS.
1	39	F	(+)	(−)	Gastric erosion Duodenitis	Chest pain Heartburn Dysphagia Odynophagia	Cervical cancer Peptic ulcer disease Migraine headaches	Cimetidine
2	50	F	(+)	(−)	Gastritis	Chest pain Dysphagia	Peptic ulcer disease Iron deficiency anemia Hypertension Subtotal Gastrectomy	(−)
3	84	F	(+)	Stricture	(−)	Dysphagia	Reflux esophagitis Peptic ulcer disease CAHD Arthritis Benign lung nodule	Cimetidine
4	42	M	(+)	(−)	(−)	Epigastric pain with burning	(−)	$NaHCO_3$ (½ Tbsp) in 4 oz. H_2O—3 times per week

began also to complain of epigastric and chest pain, heartburn, dysphagia, and odynophagia. The patient was more distressed by these complaints than her initial problem. Subsequent esophagogastroduodenoscopy revealed white cheesy material coating the mucosa of the distal and middle esophagus. Gastric erosion was seen at the antrum of the stomach, as well as severe duodenitis. Esophageal cytology revealed candidiasis. (Figure 1) Biopsy findings confirmed the diagnosis of candidiasis. (Figure 2) There was no oral candidiasis. Treatment consisted of nystatin 200,000 U. given orally four times a day. The symptoms improved immediately after initiation of treatment.

Case Two

A 50-year-old white female presented complaining of nausea, abdominal pain, chest pain, inability to eat, and dysphagia for several weeks prior to admission to the hospital. She felt as if swallowed food reached the distal portion of the esophagus and stopped there.

At the time of admission to the hospital her medications included 50mg chlorthalidone daily, 25mg amitriptyline at bedtime, and ferrous sulfate. Surgical history included total abdominal hysterectomy with bilateral salpingoophorectomy and a subtotal gastrectomy with a Billroth I anastomosis for duodenal ulcers nine years before. She was known also to have iron deficiency anemia.

Chest x-ray, electrocardiogram, and barium enema were found to be normal. Esophagram and upper gastrointestinal studies suggested esophagitis or monilial esophagitis at the middle and distal esophagus. Laboratory analysis revealed a sedimentation rate of 25mm/HR, hemoglobin 9.7%, hematocrit 29.7gm/dl, serum iron 7mcg/dl, unsaturated iron binding 386mcg/dl, and the iron saturation only 2%, with a normal chemistry profile. Bone marrow examination revealed mildly hypercellular normoblastic bone marrow, moderate erythroid hyperplasia, and absent storage iron. Skin testing for cellular immunity was positive for mumps and negative for PPD.

On the fifth hospital day, esophagogastroduodenoscopy revealed red and hyperemic mucosa at the distal esophagus. White cheesy substance was found at the middle esophagus. Severe gastritis was seen at the anastomotic area. Biopsy sections revealed marked acute and chronic esophagitis with *Candida* at the superficial area. Cytology showed candidiasis. Nystatin therapy was begun at 500,000 U. orally three times a day and was later changed to ketoconazole (200mg) twice a day for patient convenience. Symptomatic improvement was noted within the first two days of therapy.

Case Three

An 84-year-old white male nursing home resident presented with dysphagia. History included prior prostate surgery, cellulitis of the leg, coronary artery heart disease, arthritis, and a benign lung nodule. He had a three year history of reflux esophagitis and stricturing.

The patient was taking several medications, including nitroglycerin, hydrochlorothiazide and triamterene, docusate calcium, dipyridamole, quinine sulfate, ibuprofen, and cimetidine. Chemistry profile and complete blood count were normal, while the sedimentation rate was elevated at 47mm/hr.

During the three years we had known this patient, the sedimentation rate had never been normal. This was probably due to his arthritis. Skin testing for evaluation of cellular immunity was positive for *Trichophyton.* Esophagogastroduodenoscopy with dilatation for esophageal stricturing had been performed twice—three years before and again one year prior to this admission. Therapy with cimetidine had been initiated three years earlier due to multiple duodenal ulcers.

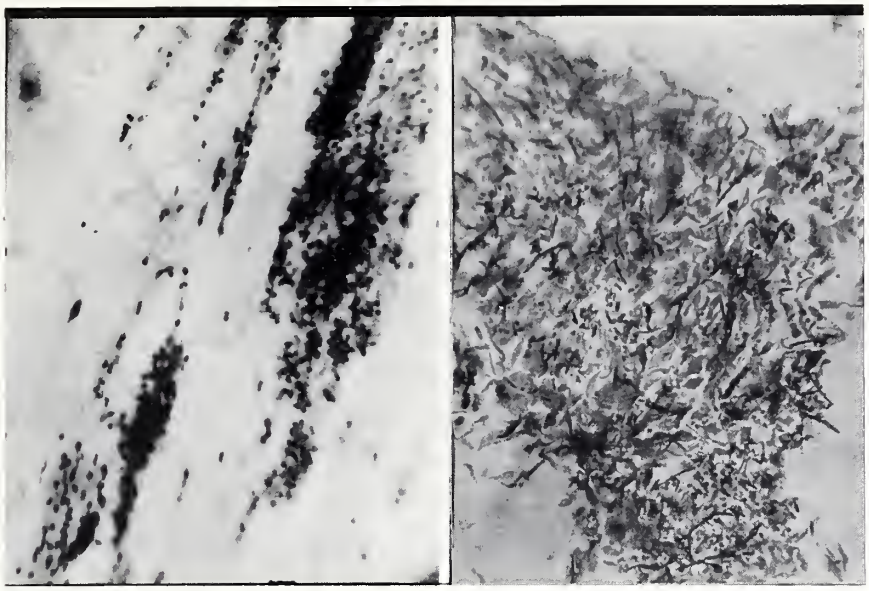


Figure 1A (left)
Smear of esophagus mucosa with Papanicolaou stain showing mature squamous cells and inflammatory cells. The evidence of Candida *is not clearly seen.*

Fig. 1B (right)
Smear of esophagus mucosa with periodic acid-shiff stain showing yeast and pseudohyphae of Candida.

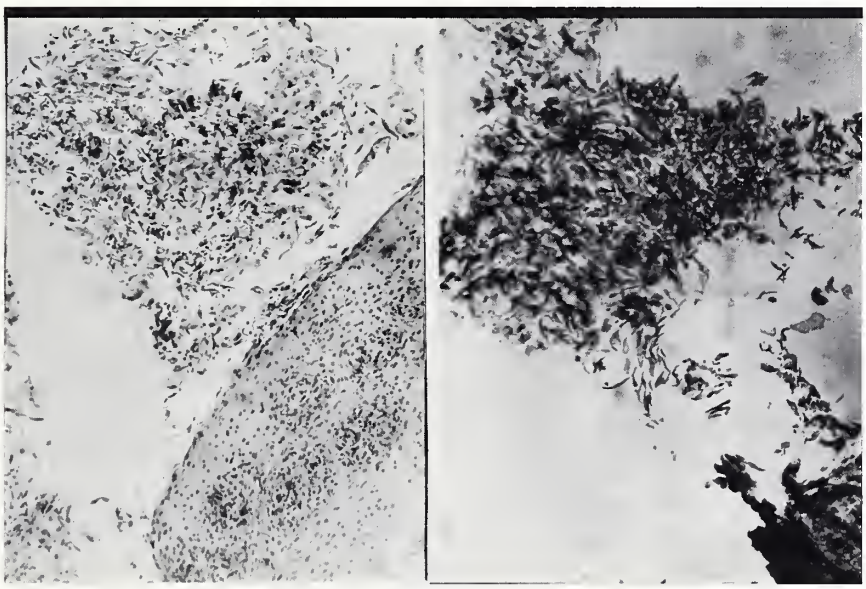


Fig. 2A (left)
Biopsy section of esophagus with H&E stain showing mature squamous epithelium and inflammatory cells. The evidence of Candida *is not clearly appreciated.*

Fig. 2B (right)
Biopsy section of esophagus with Gomori methenamine silver stain showing many pseudohyphae of Candida.

He had presented with no evidence of monilial infection during these prior endoscopies. During this episode, however, esophagogastroduodenoscopy revealed a completely normal looking stomach and duodenum. In the upper and middle esophagus a yellowish-white patch compatible with *Candida* was seen coating the mucosa. A dilatation was also performed. The diagnosis of candidiasis was established through cytological smears of the esophagus which showed *Candida.* Biopsy of esophageal mucosa showed acute and chronic inflammation with *Candida.* Treatment was then begun with 200,000U. of nystatin, four times a day, taken orally, and the patient immediately felt better.

Case Four

A 42-year-old white male presented with symptoms of epigastric pain and burning sufficiently severe to awaken him. At this time he was taking no medication and had no history of any major illness or surgery. He had been using sodium bicarbonate, (one half tablespoon in one half glass of water) about three times per week in an attempt to relieve his epigastric symptoms.

Complete blood count, sedimentation rate and chemistry profile were all found to be normal, with the exception of the alkaline phosphatase, which was 162IU/L. Both upper gastrointestinal and small bowel studies were found to be normal. Skin testing for evaluation of cellular immunity was positive for mumps. Esophagogastroduodenoscopy revealed a yellowish-white patch at the distal esophagus. Esophageal biopsy and cytology revealed candidiasis. This patient was treated with ketoconazole (200mg) twice daily and cimetidine four times a day, with immediate symptomatic improvement.

Discussion

C. albicans is part of the normal flora of the "normal" gastrointestinal tract, and, therefore, any factors that influence the gastrointestinal environment may increase its growth in the normal habitat. In a study done by Cohen, *et al.,* which included 86 specimens in 27 normal adults, *C. albicans* was found to be

the most frequent fungus, found in high concentrations in all areas sampled. High concentrations are defined as 10^2 colonies per milliliter or greater. Further, we have defined normal as the absence of any of the predisposing factors, such as diabetes mellitus, endocrinopathies, AIDS, or immunosuppression. In terms of percentage, the prevalence of *C. albicans* in the colon[7] was 65%, ileum 55%, jejunum 54%, and oropharynx 30%. It is important, however, to note that this study only reviews selectively the prevalence of *C. albicans* within the fungal flora. What then, comparatively speaking, is the rank of fungi in contrast to other substantial organisms of the fecal microflora? According to Gorbach, *et al.*, fungi proved to be the least prevalent of the eight most predominant microorganisms found in the feces of 60 normal individuals. In addition, fungi proved to be less common in 20 to 69-year-old adults, while past the age of 70, the colony counts were seen to increase significantly. This study also suggests that the number of bacteria tends to be stable unless altered by illness or drugs.[8]

We have thus far established the presence of *Candida* in the gastrointestinal tract. What then, more specifically, is the incidence of *Candida* infection in the esophagus? In terms of gastro-esophageal candidiasis, Scott and Jenkins found a 4% incidence in their survey group of 465 endoscoped patients. This 4% consisted of 19 subjects, of whom 12 (2.5%) demonstrated specifically esophageal candidiasis. Most of these patients, however, had underlying problems, such as malignancy or local pathology. Further, of these 12, three demonstrated esophageal adenocarcinoma, two had local pathology, one was using a steroid inhaler, and one had colon cancer. This left five who actually displayed no esophageal pathology. The authors drew from this information the possibility that the candidiasis may have been secondary to mucosal damage, or underlying conditions such as malignancy or medications which could alter the cellular immunity.[9] One might also conclude that the two individuals who displayed only hiatal hernia with no local pathology were primary cases, and of noteworthy significance. In 1979 Kawai *et al.* reported two cases of primary gastroduodenal candidiasis in healthy patients.[10]

Of the cases which have been presented, three were primary, while the fourth could have been a secondary infection. As mentioned previously, three of the four shared a common factor: each had less than normal amounts of gastric acid. In two, this was due to cimetidine therapy and in one to a subtotal gastrectomy with a Billroth I anastomosis. The remaining subject had used sodium bicarbonate. As the normal gastrointestinal habitat has been disturbed, is it not reasonable to suggest that this may be a factor in the findings of candidiasis in the normal subject?

In 1966, Borg, *et al.*, reported three cases of gastric yeast infection found in the residual stomach following Billroth I type gastrectomy.[11] These patients complained of a lump in the epigastrium area, early satiety, and vomiting. Radiologically all three presented a bezoar-like mass in the gastric remnant. It is carefully noted that there was no free HCl in any of these subjects.

In 1974, Brooks, *et al.*, reported increased incidence of positive cultures for *C. albicans* in the stomachs of patients post-vagotomy. Intraoperative cultures taken pre-vagotomy in 63 subjects found *Candida* to be present in only 8%. In the postoperative, post-vagotomy group, 80% of 50 subjects were culture-positive for *Candida.* This finding has been attributed to the altered pH of the stomach following vagotomy. The pH of pre-vagotomy, normal individuals has been shown to average 1.9, as compared to individuals with ulcers, whose pH averages about 1.46. However, following vagotomy the pH is seen to rise to an average of 3.7, being more conducive to fungal growth.[12]

Conclusion

We are finding that *Candida* esophagitis seems to be more common now in normal, healthy patients. This may be due to the fact that more endoscopy procedures are being done, or that more people are using cimetidine, causing a decrease in acid production, thus promoting the growth of *C. albicans.* In any case it is very difficult to determine which of these factors may be responsible for the increasing incidence of esophageal candidiasis in healthy patients. In conclusion we would like to make the following points:

- Not all of the chest pain and heartburn are due to peptic reflux esophagitis. Empiric treatment with cimetidine, without esophageal examination, may be more harmful to the patient.
- When patients taking cimetidine for peptic ulcer disease develop heartburn or chest pain, possible *Candida* infection of the esophagus should be considered.
- In patients with a known history of peptic esophagitis or stricturing, the worsening of the symptoms may be due to esophageal candidiasis.
- Prolonged use of cimetidine may be one of the factors that lead to esophageal candidiasis.

References

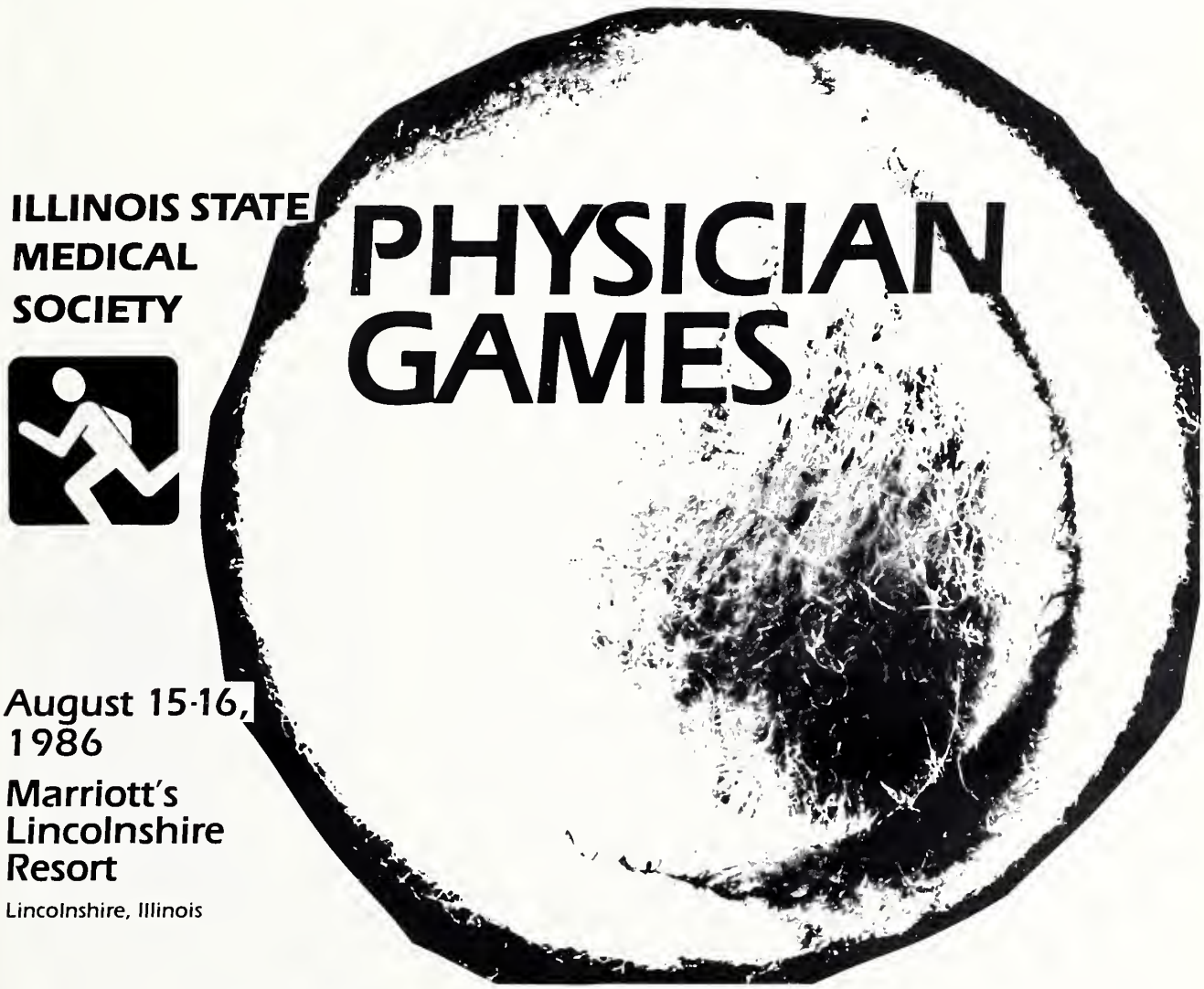
1. Mathieson, R., Dutta, S. K.: "Candida Esophagitis," *Digestive Diseases and Sciences* 28:365-370, 1983.
2. Kirkpatrick, C. H.: "Host Factors in Defense Against Fungal Infections," *Am J Med* (Candidiasis symposium) 10/30:1-11, 1984.
3. Trier, J. S., Bjorkman, D. J.: "Esophageal, Gastric, and Intestinal Candidiasis." *Am J Med* (Candidiasis symposium) 10/30:39-43, 1984.
4. Trier, J. S., Bjorkman, D. J.: "Esophageal, Gastric, and Intestinal Candidiasis," *Am J Med* (Candidiasis symposium) 10/30:39-43, 1984.
5. Obrecht, W. F., Richter, J. E., *et al.*: "Tracheoesophageal Fistula: A Serious Complication of Infectious Esophagitis," *Gastroenterology* 87:1174-1179, 1984.
6. Blackstone, M. O.: Endoscopic Interpretation, Normal and Pathologic Appearances of the Gastrointestinal Tract, New York, New York: Raven Press, 1984, pg. 25.
7. Cohen, R., Roth, F. J., *et al.*: "Fungal Flora of the Normal Hu-

man Small and Large Intestine," *New Eng J Med* 3/20:638-641, 1969.
8. Gorbach, S. L., Nahas, L., *et al.*: "Studies of Intestinal Microflora I. Effects of Diet, Age, and Periodic Sampling on Numbers of Fecal Microorganisms in Man," *Gastroenterology* 53:845-855, 1967.
9. Scott, B., Jenkins, D.: "Gastro-Oesophageal Candidiasis," *Gut* 23:137-139, 1984.
10. Minoli, G., *et al.*: "Gastroduodenal Candidiasis Occurring without Underlying Diseases (Primary Gastroduodenal Candidiasis)," *Endoscopy* 1;18-22, 1979.
11. Borg, E., *et al.*: "Massive Growth of Yeasts in Resected Stomach," *Gut* 1:244-249, 1966.
12. Brooks, J. R., *et al.*: "Bacteriology of the Stomach Immediately Following Vagotomy: The Growth of Candida Albicans," *Ann Surg* 179:859-862, 1974.

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FURTHER INFORMATION

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Herpes Simplex and *Candida* Esophagitis

By Jose Kogan, M.D., Evanston

Two patients with ulcerative esophagitis secondary to esophageal invasion with herpes simplex are reported. Microscopic examination of the esophageal mucosa revealed multinucleated cells and intranuclear inclusions typical of herpes simplex infection. Herpes simplex virus and Candida albicans *were cultured from each patient.*

In 1943, Pearce and Dagradi first described acute ulcerative esophagitis evidenced by cytologic examination and presumed to be caused by the herpes simplex virus.[1]

Until recently, herpes esophagitis has been essentially a postmortem diagnosis[2] with a general incidence of 0.5%-0.76% (based on retrospective studies).[3] The antemortem diagnosis is usually confined to extremely debilitated and immunosuppressed patients.

Case 1

A 65-year-old white male presented complaining of progressive dyspnea on exertion. He had a 12-year history of non-Hodgkin's lymphoma (lymphocytic type, well-differentiated, nodular) that had been in apparent remission for several years following oral cyclophosphamide therapy. A large pleural effusion was found on physical examination. Pleural biopsy revealed infiltration by lymphoma. CAT scan of the chest documented enlargement of the anteriosuperior mediastinum, as well as enlargement of the medium-sized lymph nodes anterior and posterior to the carina. Bone marrow biopsy confirmed presence of malignant lymphoma. Combination chemotherapy was initiated utilizing cyclophosphamide, vinicristine and prednisone on a three week cycle.

After the completion of four chemotherapy cycles, the patient started to complain of an excruciating burning sensation in the midsternal area associated with swallowing. He did not report fever, chills, nausea or vomiting. Physical examination revealed no acute distress with normal vital signs. Ulcerated vesicles on the lower lip were discovered during the EENT examination. Rhonchi and wheezing were auscultated throughout both lung fields and some dullness was noted upon percussion in the left base. The abdomen was soft and not tender. The liver was nonpalpable; the tip of the spleen was palpable. Laboratory data revealed a WBC of 3,000, RBC of 3.97, hemoglobin of 11.7 and platelet count of 80,000 with normal differential count. Herpes virus titer was 1:64. An esophagogram was essentially normal. The upper gastrointestinal endoscopy revealed discrete punched-out esophageal ulcerations in the midportion of the esophagus, with inflammatory exudate present on some. The cytological smear performed from the esophageal brushing showed multinucleated giant cells with a ground glass appearance. Intranuclear inclusion bodies were also identified. (Figure 1) The herpes simplex virus and *Candida albicans* were isolated from the cultures. The patient was



Figure 1. Microscopic examination of the esophageal brushing revealed nucleated cells and intranuclear inclusions.

started on ketoconazole 200mg. q.i.d. and acyclovir 300 mg. every eight hours intravenously for 10 days. His symptoms improved.

Case 2

A 70-year-old white female was admitted to the hospital following a three-week history of nontender bilateral swelling in the groin. Fever, chills and weight loss were not reported. Physical examination revealed no acute distress. Blood pressure was 120/80; temperature was normal. Review of systems did not reveal any abnormalities of chest, lungs, heart or EENT. The tip of the spleen was thought to be possibly palpable. Nontender lymph node enlargement was present in the left axillary area and both inguinal areas. CBC, SMA, urinalysis and chest x-ray were normal. CAT scan of the abdomen revealed some enlargement of the abdominal lymph nodes. Pathologic diagnosis from the lymph node biopsy was compatible with histocytic lymphoma. Systemic chemotherapy was initiated, utilizing cyclophosphamide, vincristine and prednisone on a three week cycle. Following several weeks of therapy, the patient complained of odynophagia to solids and liquids, a low grade fever and fatigue. X-rays of the upper gastrointestinal tract were essentially normal. Herpes virus titer was not done. Endoscopic examination of the gastrointestinal tract revealed multiple ulcerations in the middle and lower esophagus with normal-appearing mucosa between. Brushing obtained from the esophagus revealed multinucleated giant cells. Herpes and candida cultures were positive. At this time the chemotherapy was discontinued. Following symptomatic treatment, the patient recovered completely. (Figure 1)

Discussion

Infectious ulcerative esophagitis is not common. When it is diagnosed, *Candida albicans* is the most frequently isolated organism.[4-5] Those cases diagnosed and attributed to the herpesvirus are usually confined to immunosuppressed patients or those with hematologic malignancies.[6-8]

Herpetic esophagitis has been associated less frequently with renal transplants, cutaneous burns, ulcerative colitis, corticosteroid therapy, chemotherapy and radiotherapy and normal healthy adults.[9-11]

The virus invades the squamous cells to produce the characteristic intranuclear inclusion bodies. This is followed by epithelial destruction, forming ulcers that gradually enlarge as the virus progressively infects and destroys neighboring cells. Secondary infections by bacteria and fungi are almost inevitable in the immunosuppressed patient. These account for the chronic nature of the process and can lead to gastrointestinal bleeding.[12,13] It is important to recognize that other members of the herpesvirus group, including varicella zoster and cytomegalovirus, can produce intranuclear inclusions indentical to herpes simplex.[14] However, the intranuclear inclusions produced by CMV are located in endothelial cells and fibroblast along the ulcer bed[15] rather than in squamous epithelial cells adjacent to the ulcers.

When viral esophagitis occurs in an otherwise healthy person, it is during the course of an influenza-like illness or in association with other viral infections. Patients with herpes esophagitis often have lesions in the mouth which can provide an early clue to the diagnosis. However, the absence of oropharyngeal herpes does not preclude the diagnosis of this entity. The classic finding in patients with herpes esophagitis is odynophagia; the pain is usually substernal. Unfortunately, symptoms in moniliasis are identical, and as both may coexist, it is rarely possible to differentiate these entities on clinical grounds alone. As a result, there may be a small but significant incidence of coexisting fungal and viral esophagitis in patients treated for presumed moniliasis.

The endoscopic appearance of herpes esophagitis has been well-established. It begins with vesicle formation, followed by discrete, punched-out ulcers which become covered with fibrinous exudate and debris. Later, the ulcers may coalesce, resulting in a diffuse erosive esophagitis. Unfortunately, the characteristic vesicles that differentiate herpes from other causes of esophagitis are only visible in the early stages of infection. By the time most patients undergo endoscopy, there are extensive ulcerative and exudative lesions which are nonspecific in nature and cannot be distinguished from candidiasis.

Radiographic examination, especially air contrast esophagography, may reveal discrete, widely-separated ulcers, plaque-like defects, or a combination of both. However, these findings are non-specific. The diagnosis of esophageal herpesvirus infection is established by the demonstration of the cytopathic change in the squamous epithelium. Tissue culture isolation of the herpesvirus and a four-fold rise in complement-fixing antibodies are further confirmation.

Most patients recover without specific therapy, and without sequelae. Symptomatic relief may be afforded by the use of topical anesthetics and antiviral therapy, specifically, cytosine arabinoside, 20mg. per square meter, administered daily for three days.[16]

The effects of antiviral agents have been greatly hampered by toxicities resulting from their nonspecific action. Acyclovir using HSV-specific thymidine kinase combines a potent antiviral action with a low host toxicity. Other than cellular toxicity, transient rises in serum urea and creatinine[17] have been reported. The recommended dosage is 5 mg./kilo body weight every eight hours for five to ten days. Manufacturers advise that good hydration is necessary. They further suggest that acyclovir be given by intravenous infusion over one hour to protect against kidney impairment.

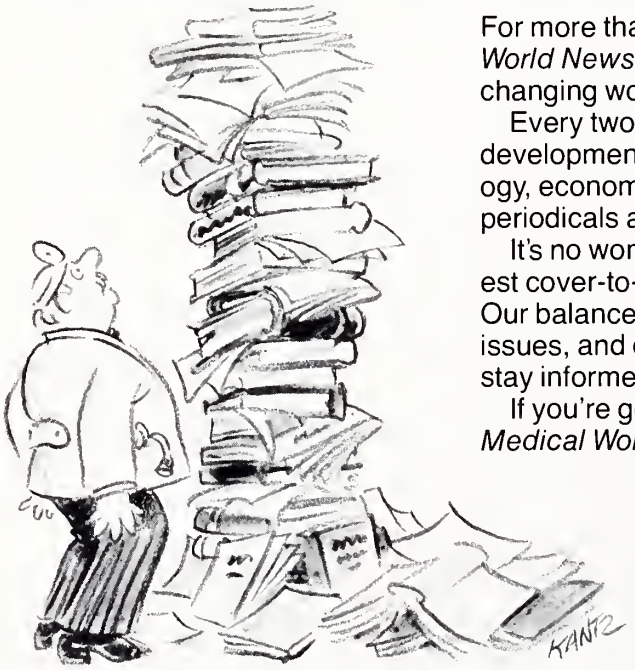
References

1. Pearce, J., Dagradi, A.: "Acute Ulceration of the Esophagus with Associated Intranuclear Inclusion Bodies," *Archives of Pathology* 35: 889-897, 1943.
2. Nash, G., Ross, J.S.: "Herpetic Esophagitis; A Common Cause of Esophageal Ulcerations," *Human Pathology* 5: 339-45, 1974.
3. Rosen, P., Hajdu S.I.: "Visceral Herpes Virus Infection in Patients with Cancer," *American Journal of Clinical Pathology*" 56: 459-65, 1971.

4. Goldberg, H.I., Dodds, W.J.: "Cobblestone Esophagus Due to Monilial Infections," *American Journal of Roentgenology* 104: 608-612, 1968.
5. Eras, P., Goldstein, M.J., Sherlock, P.: "Candida Infections of the GI Tract," *Medicine* 51: 367-379, 1972.
6. Weiden, P.L., Schuffler, M.D.: "Herpes Esophagitis Complicating Hodgkin's Disease, *Cancer* 33: 1100-1102, 1974.
7. Howiler, W., Goldberg, H.I.: "Gastroesophageal Involvement in Herpes Simplex," *Gastroenterology* 70: 775-778, 1976.
8. Lightdale, C.J., Wolf, D.J., Marcucci, R.A., Salyer, W.R.: "Herpetic Esophagitis in Patients with Cancer; Ante Mortem Diagnosis by Brush Cytology," *Cancer* 39: 233-236, 1977.
9. DePrew, W.T., Prentice, R.S.A., Beck, I.T., *et al:* "Herpes Simplex Ulcerative Esophagitis in a Healthy Subject," *American Journal of Gastroenterology* 68: 38, 385, 1977.
10. Owensby, L.C., Stammer, J.L.: "Esophagitis Associated with Herpes Simplex Infections in an Immuno-Competent Host," *Gastroenterology* 74: 1305-1306, 1978.
11. Springer, D.J., Dacosta, L.R., Beck, I.T.: "A Syndrome of Acute Self Limiting Ulcerative Esophagitis in Young Adults," *Digestive Diseases and Sciences* 24: 7, 1979.
12. Fishbein, P.G., Tuthill, R., Kressel, H., Friedman, H., Snape, W.J. Jr.: "Herpes Simplex Esophagitis A Cause of Upper Gastrointestinal Bleeding," *Digestive Diseases and Sciences* 24: 7, 1979.
13. Solammadevi, S.V., Patwardhan, R.: "Herpes Esophagitis," *American Journal of Gastroenterology* 77: 1, 48-50, 1982.
14. Nash, G., Foley, F.D.: "Herpetic Infections of the Middle and Lower Respiratory Tract," *American Journal of Clinical Pathology* 54: 857-863, 1970.
15. Henson, D.: "Cytomegalovirus Inclusion Bodies in the Gastrointestinal Tract," *Archives of Pathology* 93: 477-482, 1972.
16. Weiden, P.L., Schuffler, M.D.: "Herpes Esophagitis Complicating Hodgkin's Disease," *Cancer* 33: 1100-1102, 1974.
17. Harrington, M.G., Durward, W.F.: "Renal Impairment and Acylclovir," *Lancet* 2: 1281, 1981.

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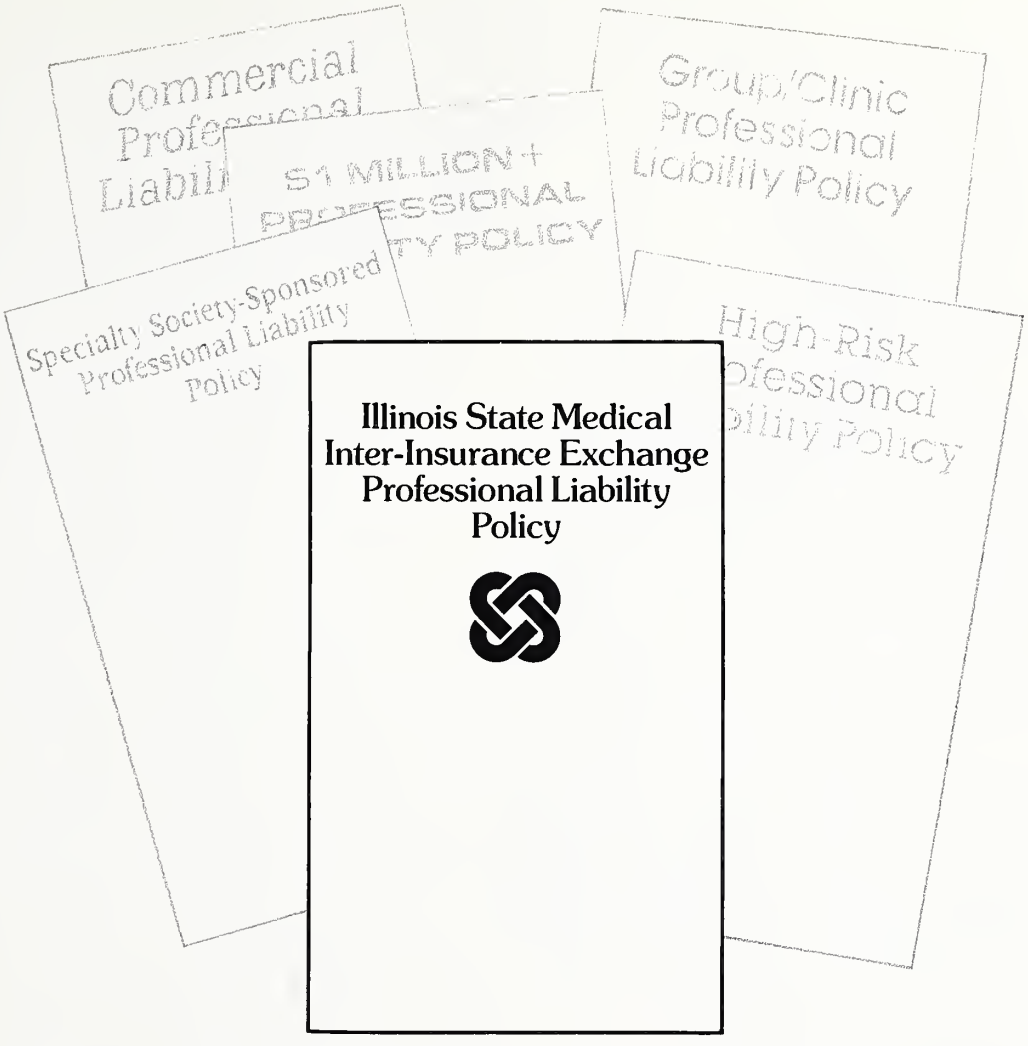
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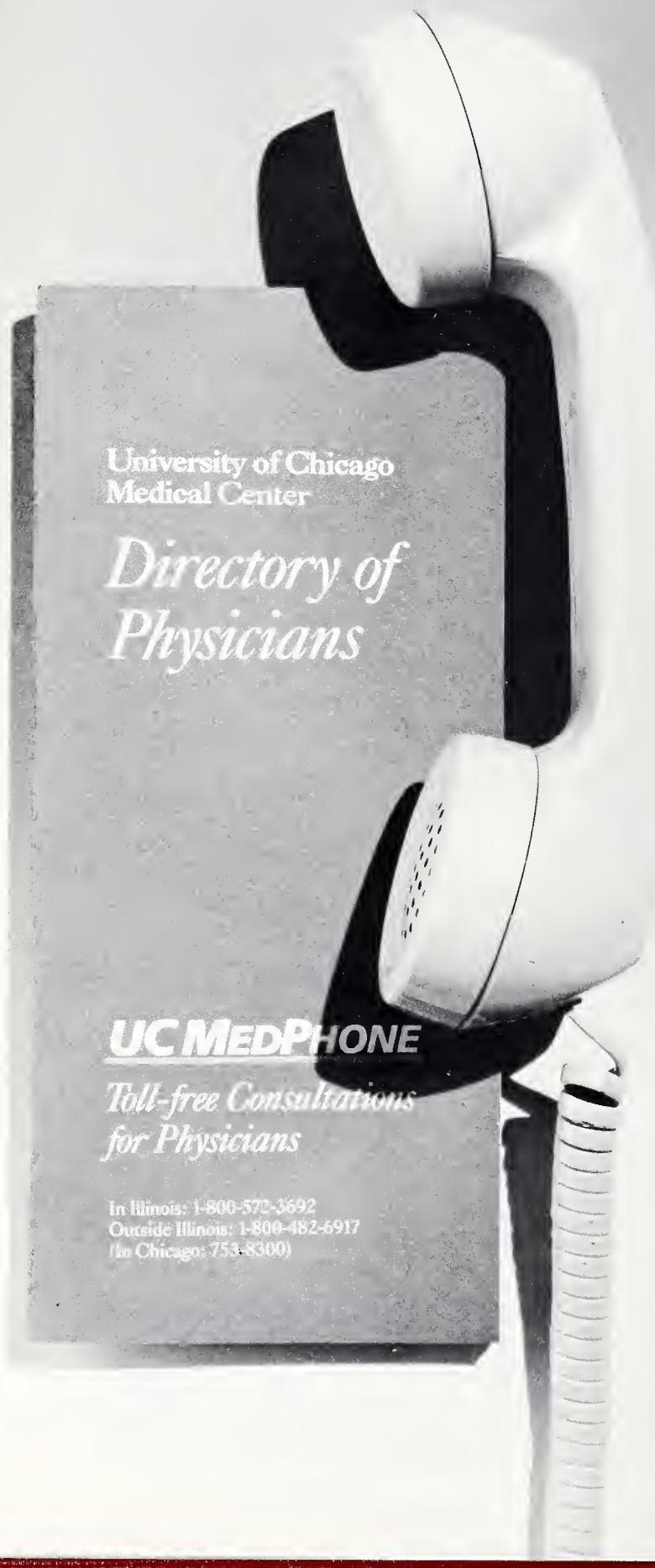
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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Sixty-eight healthy post-menopausal women at least six months post-menarche and without a history of low back pain were evaluated as to bone density in the area of L2-4 vertebrae by dual-photon absorptiometry and evaluated as to back extensor strength by strain gauge dynamometry. All patients were on a general diet without medications or vitamin-mineral supplements. All patients were over 49 years in age. Height, weight and arm span were measured in all patients. The authors found a positive correlation between bone mineral content in the lumbar spine and height, weight, and back extensor strength. Women with osteoporosis were shorter, lighter, had a shorter arm span and exhibited weaker paravertebral muscles. (Sinaki, M., *et al: Mayo Clin Proc* 61:2, 116-122, 1986)

Blunt trauma to the heart occurs more frequently than is suspected. The authors present five cases with atrial rupture due to motor vehicle accidents. If these patients can reach a treatment facility promptly, they may be saved by prompt surgical intervention. Between 50,000 and 60,000 persons die in the U.S.A. each year due to motor vehicle accidents and approximately 10-15% of these victims die of myocardial rupture. (Getz, B. *et al: JAMA* 255:6, 761-3, 1986)

Nocturnal asthma was treated by day or evening doses of sustained release theophylline. Blood levels and symptom alleviation were evaluated. Evening doses showed higher peak and trough concentrations with higher levels noted in early morning. Nocturnal doses were suggested for patients with nocturnal asthma. (Busse, W., Bush, R.: *Am J Med* 79:6A, 62-66, 1985)

Two hundred and five patients with episodes of carotid transient ischemic attacks were evaluated as to etiologic factors. Ipsilateral carotid bruit and TIA induced by exercise or standing were found to suggest a carotid lesion. Angina attacks or palpitations at onset of TIA suggested a cardiac source of emboli. No other relationships could be drawn between symptoms and etiologies. (Bogousslavsky, J., *et al: Arch Neurol* 43:3, 229-33, 1986)

Hyperlipoproteinemia is associated with coronary disease, carotid occlusive disease, pancreatitis and xanthomatous skin lesions. It generally results from excess production or decreased removal, rather than as a primary genetic disorder. Low density lipoprotein is the principal cholesterol-carrying molecule and accounts for 70% of the total plasma cholesterol. The ideal upper limit of serum cholesterol is 150 plus the patient's age, in mgm/dL. Patients who smoke, are hypertensive or diabetic, or have a strong family history of coronary heart disease are not responsive to dietary treatment of hypercholesterolemia. Pharmacologic approaches are suggested if total cholesterol and triglyceride levels are elevated on at least two occasions after fasting 14 hours and the high density to low density lipoprotein cholesterol ratios are greater than 0.3. Therapy may consist of diet, niacin, nicotinic acid with bile acid sequestrants or cholestyramine, colestipol, and dextrothyroxine in patients without coronary disease and under the age of 30. (Lueg, M., Anding, R.: *Hosp Pract* 21:1A, 112-122, 1986)

Incidence of degenerative joint disease in the lower extremities is no greater among individuals who run for exercise than in more sedentary persons. Rates of reported pain, swelling of hips, knees, ankles, and feet, and other musculoskeletal complaints were comparable among runners and non-runners. Radiologic examinations for osteophytes, cartilage thickness, and degenerative joint diseases were not different. (Panush, R., *et al: JAMA* 255:9, 1152-4, 1986)

A rational approach to the prevention of cardiovascular disease should begin early in life. A study of records for 35 persons whose mean age at death was 18 years, showed a marked relationship between lipoprotein cholesterol and hypertension and fatty streaks to fibrous plaques in the aorta and coronary arteries. (Newman, W., *et al: N Engl J Med* 314:3, 138-43, 1986)

Persons over 40 years of age with serum cholesterol levels over 240mg/dl are at increased risk of coronary heart disease. Trials indicate that for every 1% reduction in serum cholesterol, there is a 2% reduction in the incidence of coronary heart disease. A National Cholesterol Education Program is being promulgated by 22 health organizations. Physicians will be asked to assist in the evaluation and education programs. (Marwick, C.: MEDICAL NEWS, *JAMA* 255:9, 1097-1102, 1986)

Measurements of trunk flexibility are used diagnostically, prognostically and as therapeutic guides. The authors evaluated the efficacy, reproducibility, and accuracy of the fingertip to floor, modified Schober and Moll tests, and Loebl inclinometer for trunk mobility. Twenty-five normal and healthy men, and twenty-five normal and healthy women, were tested on three separate occasions by the same examiners and by three different examiners for accuracy. The Schober test measuring a 15cm distance from S1 cephalad on trunk standing erect and on flexion, distances on lateral trunk flexion from iliac crest cephalad in standing and lateral bending, and lumbar trunk flexion measured by a goniometer, were found to be reproducible. (Merritt, J., *et al: Mayo Clin Proc* 61:3, 192-7, 1986)

DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Eli L. Borkon, M.D., Carbondale, was named recipient of the Southern Illinois Medical Association's 1985 Physician of the Year award. A professor emeritus of the Southern Illinois University School of Medicine and former member of the *IMJ* Editorial Board, Dr. Borkon serves as a member of the State of Illinois Medical Disciplinary Board . . . . **Jeffrey G. Shanes, M.D.,** Skokie, has been named a fellow of the American College of Physicians.

Chicago Medical Society President-Elect **Pedro A. Poma, M.D.,** Melrose Park, has been named to the Mayor's Advisory Committee on Infant Mortality, which seeks to bring health and social service organizations together in working to reduce the infant mortality rate . . . . **Vincent A. Costanzo, M.D.,** director of the Jackson Park Hospital and Medical Center Family Practice Center, was named 1985-86 honorary president by the Illinois Pharmacists Association. Dr. Costanzo, who is both a pharmacist and a physician, is chairman of the ISMS Committee on Drugs and Therapeutics . . . . **Robert J. Becker, M.D.,** Lombard, has been named president-elect of the American College of Allergists. Dr. Becker is a former president of the Illinois Society of Internal Medicine and a former member of the ISMS House of Delegates.

Lawrence J. Rossi, M.D., Hopedale, has been selected as one of five citizens honored by the Lincoln Academy of Illinois for contributions to society . . . . **Peter McKinney, M.D.,** Chicago, has been re-elected secretary of the American Society for Aesthetic Plastic Surgery . . . . April 5 was "Dr. Downie Day" in Kankakee, when **Gerald L. Downie, M.D.,** was honored for his lifelong work as a medical missionary in China, Rhodesia, India, Taiwan and Malaysia and also with the poor people of Kankakee County. Dr. Downie, who continues to practice at the age of 83, is a former recipient of the ISMSA Humanitarian Award.

Violeta Centeno Beltran, M.D., Chicago, is the recipient of the Chicago Medical Society's ninth annual Public Service Award. Dr. Beltran was recognized for community service, particularly as distinguished in her work with the Salvation Army Booth Memorial Hospital . . . . **Joseph Danon, M.D.,** Oak Park, is 1986 medical staff president at St. Mary of Nazareth Hospital Center, Chicago. **Dr. Michael R. Treister,** Chicago, has been named president-elect and **Dr. Mrugendra Gandhi** was elected secretary at St. Mary's.

Miles Lynch, M.D., Mount Prospect, is the medical staff president at Northwest Community Hospital in Arlington Heights. **Thomas Kim, M.D.,** Long Grove, will serve as vice president this year and **Ralph Casciaro, M.D.,** Arlington Heights, will serve as secretary-treasurer . . . . **Rabi F. Sulayman, M.D.,** has been named chairman of the department of pediatrics at Christ Hospital and Medical Center, Oak Lawn.

The University of Illinois College of Medicine at Chicago named two new department heads earlier this year. **David K. Webb, M.D.,** Mahomet, will head the department of family practice at the Urbana-Champaign campus. **Donald MacLean, M.D.,** Rockford, will chair the psychiatry department at the Rockford campus.

Medical staff officers for St. Elizabeth's Hospital, Chicago are **Hugo R. Velarde, M.D.,** Highland Park, president, **Myroslaw Cherny, M.D.,** Chicago, president-elect, and **Zenaida Racho, M.D.,** Morton Grove, secretary-treasurer . . . . **John Saletta, M.D.,** Glenview, has been named president of the Illinois Surgical Society. Dr. Saletta is chairman of the division of surgery at Lutheran General Hospital, Park Ridge.

CHEMONUCLEOLYSIS WITH CHYMOPAPAIN

The *Journal* has been advised of a clinical session exploring the efficacy of chemonucleolysis with chymopapain for low back pain relief. In June of last year, the University of Illinois College of Medicine sponsored a symposium on the subject. Persons interested in learning more about the results of that meeting may contact Ronald P. Pawl, M.D., Associate Professor, Department of Neurosurgery, UI College of Medicine, 912 S. Wood St., Chicago 60612; 312-996-4842.

WWII REUNION PLANNED

A reunion is planned for staffers of the 297th General Hospital (Cook County Unit) which left England more than 40 years ago. Persons interested in further information, or persons who can provide information about the whereabouts of former members, are encouraged to contact Louis A. Rypel, 5258 Henderson St., Chicago 60641; 312-725-2727.

RHEUMATOID ARTHRITIS PATIENTS SOUGHT

Patients between 18 and 70 years of age with active rheumatoid arthritis who are not presently taking agents for remission (*e.g.*, gold, hydroxychloroquine, pencillamine) are sought for a controlled study of a new agent in this field. Women of childbearing potential are not eligible. Physicians in the Peoria area who might wish to refer patients may contact Dr. Yunus at 309-671-3088.

Invest in Auxiliary

By Pat Spadoni (Mrs. Alex)
President, ISMSA

At the time of my installation luncheon in April, I affirmed my commitment to continuing ISMSA projects initiated during the last year: teen suicide prevention, child abuse awareness/prevention and legislative involvement. I also hope that our members will focus their energies and talents to develop projects related to older Americans during this year. By the year 2000, 31 million people, or 12% of the population, will be in their golden years. By 2050—when the "baby boomers" become "senior boomers"—more than 16 million men and women will be 85 years of age or older. Will we, as auxilians, have helped to put aside a "nest egg" of programs and services to protect and comfort us, as well as our children, during those golden years? It will be difficult to persuade people to plan for an age that seems so distant. But we must begin.

The ISMSA has never been so sound, but increasing and maintaining our membership is a perpetual goal. As a growing number of organizations seek volunteers, fewer spouses will be able to devote themselves full time to auxiliary. It will become necessary to network with other groups to "spread the risk" while simultaneously pointing to the benefits of belonging first and foremost to auxiliary. As AMAA President-Elect Pat Durham has stated, ". . . it is the most important medical organization to which you as a spouse can belong. The medical auxiliary is the only one which can provide spouses with benefits that they cannot receive from any other organization: information on physicians and their families, fellowship, skills training, education and information on issues affecting medicine."

ISMSA will try this year to refine its organizational structure and operate within budget while sufficiently capitalizing our projects without cost overruns or deficits. We have untapped resources and expertise at our disposal, and we must find and exploit them. Although we are currently overwhelmingly female, with the growing number of women physicians we must anticipate and prepare for a change in composition and gender in auxiliary.

Our retired physicians' spouses frequently decline membership because their spouses no longer pay dues. We will be looking for ways to encourage them to continue as members for several reasons. A primary reason was supplied by Dr. Mather Pfeiffenberger, on June 2, 1927, at the first temporary auxiliary meeting in Moline, Illinois. "Such an organization will help the good fellowship and sociability among doctors' wives." We are now doctors' spouses, but that comaraderie continues today to be one of the biggest benefits of auxiliary membership.

Development of programs by and for our widows is another important area. The peer support of auxiliary is most essential among these spouses and our failure to address their needs would be a failure in commitment to the medical family.

Overall, I would say that the Illinois State Medical Society Auxiliary is in a bull market, the charts look good and our projections are favorable. We are "blue chip" and offer the best returns. So "Invest in Auxiliary!" ◀

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JULY

Cardiology
Cardiac Rehabilitation
For: Interested health professionals. Workshop, July 21-25, LaCrosse, WI. **Sponsors**: University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Stress Management
Teaching Stress Management and Relaxation Skills
For: Interested health professionals. Workshop, July 14-18, LaCrosse, WI. **Sponsors**: University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed; 35 hours; Other: CEU's from UW-LaCrosse: 3.5 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Pulmonary/Cardiology
Pulmonary Circulation in Health and Disease
For: Physicians. Conference, July 8-11, Madison, WI. **Sponsors**: University of Wisconsin-Madison, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Department of Anesthesiology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 26 hours; Other: University of Wisconsin CEU's: 26 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Diagnostic Testing
Physicians' Office Testing Exposition
For: Physicians, lab technicians, etc. Exhibit/Classroom, July 15-17, 9:00 a.m.-5:00 p.m., McCormick Place, Chicago. **Sponsor:** American Association for Clinical Chemistry, 1725 K Street, NW, Suite 1010, Washington, DC 20006. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Camille Smith. **Phone:** (800) 892-1400.

Dermatology
Diagnostic Dermatology: A Workshop for Internists
For: Internists and other primary care physicians. Lecture, July 14-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $280. **Reg. Limit:** 90. **Credit:** Category 1: 20 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Emergency Medicine
Specialty Review in Emergency Medicine
For: Emergency medicine, family medicine and internal medicine physicians. Lecture, July 28-August 2, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1: 52 hours; Other: ACEP: 50 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Pediatrics
Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 21-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $730. **Reg. Limit:** None. **Credit:** Category 1: 69 hours; Other: 69 PREP. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

SEPTEMBER

Otolaryngology
Contemporary Head and Neck Reconstructive Surgery
For: Otolaryngologists. Workshop, September 24-27, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 60. **Credit:** Category 1: (hours to be determined). **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Nephrology/OB-Gyn/Family Medicine
Renal Function and Disease in Pregnancy
For: Nephrologists, obstetricians, and family practitioners. Symposium, September 18-20, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the National Kidney Foundation. **Fee:** $145. **Reg. Limit:** None. **Credit:** Category 1: 14 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Neonatology
Perinatal Care: Current Issues for the Primary Care Provider
For: Family practitioners, obstetricians and pediatricians. Seminar, September 11, Jumer's Castle Lodge, Urbana, IL. **Sponsors:** Carle Clinic Association, Educational Services, 611 W. Park Street, Urbana, IL 61801 and the University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $5. **Reg. Deadline:** 9/4/86. **Reg. Limit:** None. **Credit:** Category 1: 3.5 hours; AAFP Prescribed: 3.5 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3108.

Dermatology/Family Medicine/ Geriatrics
National Symposium on the Prevention and Treatment of Pressure Ulcers
For: Dermatologists, family practitioners, and geriatrics specialists. Symposium, September 23-25, Chicago, IL. **Sponsors:** The University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the Chicago Department of Health. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Internal Medicine/Family Practice
Office Treatment of Hypertension
For: Internists, family practitioners, cardiologists, and general practitioners. Conference, September 24, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 4 hours; AAFP Prescribed: 4 hours; and AOA: 4 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Psychiatry
Workshops for various specialties
For: Psychiatrists, anesthesiologists, family physicians, allergists, pediatricians. September 23-26, Chicago, IL. **Sponsors:** Society for Clinical and Experimental Hypnosis, 128-A Kings Park Drive, Liverpool, NY 13090; Department of Psychiatry and Department of Behavioral Sciences, University of Chicago; Department of Psychiatry, Michael Reese Hospital; Anesthesia Department, Northwestern University Medical School and Department of Psychology, University of Illinois at Chicago. **Fee:** $120-160 residents; $270-395 members; $340-480 non-members. **Credit:** Category 1: 30 hours; AAFP Elective: 30 hours; ADA: 30 hours; American Psychological Association: 30 hours. **Contact:** Marion Kenn. **Phone:** (315) 652-7299.

Critical Care/Medicine/Surgery
Fifth Annual Chicago Critical Care Symposium
For: Physicians and nurses. Lectures, tutorials, September 25-28, Chicago Marriott Hotel, Chicago, IL. **Sponsor:** University of Health Sciences/The Chicago Medical School, c/o Liz Bruechert, CME Office, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $360 for physicians, $220 for nurses. **Reg. Limit:** None. **Credit:** Category 1: 24 hours; AAFP Prescribed: 24 hours; AACN: 24 hours; and ACEP: 24 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Emergency Medicine
6th Annual Current Emergency Care Problems Conference
For: Physicians. Conference, September 11-12, Madison, WI. **Sponsor:** University of Wisconsin-Madison, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Emergency Medical Services Program, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; AOA Category 2-D: 11.5 hours; and Univ. of Wisconsin CEUs: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

October

Psychiatry
The Psychiatric Interview
For: Psychiatrists. Course, October 17-19, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Ob/Gyn/Geriatrics/Pediatrics/Urology
Medical Seminar-at-Sea (Mediterannean/Holy Land Cruise)
For: Physicians. October 19-November 1. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine
17th Family Medicine Review
For: Family physicians. Course, October 26-31. **Sponsor:** University of Kentucky College of Medicine, Office of CME, 132 COM Office Building, Lexington, KY 40536. **Fee:** $425 ($450 after 10/10). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP: 50 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Neurology
Clinical Neuroimmunology IV: Demyelinating Diseases and AIDS
For: Neurologists. Course, October 23-25. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

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How to Hire a Medical Assistant

By Lesa Hildebrand, CMA-C, Triton College/River Grove

Have you ever needed to hire a medical assistant but cringed at the thought of interviewing countless unqualified individuals responding to a newspaper ad? Many persons are not aware of the medical assisting profession. As a result, many other allied health personnel consider themselves medical assistants, since they do, in fact, assist a physician in some capacity. However, most of these professionals are not as diversified as the medical assistant.

The state of Illinois offers four CAHEA-accredited medical assisting programs, all of which provide a variety of administrative and clinical skills. Administrative skills include typing, insurance coding, exposure to computer use, machine transcription, and minor training in bookkeeping and accounting. Some clinical skills include vital signs, ECGs, phlebotomy, laboratory skills and audiometry. The programs range in length from one to two years. Graduates of the one year programs receive a certificate or diploma, while graduates of two year programs receive an associate degree in applied science.

All of the accredited medical assisting programs provide an externship for the students. This externship is generally offered near completion of the formal program and enables the student to utilize all of the skills gained from the program. The student receives credit for this externship. He or she wears a uniform and functions like any other office employee.

Most programs conclude at the end of May. Graduates are strongly urged to take the national certifying examination for medical assistants, developed in consultation with the National Board of Medical Examiners, offered on the first Friday in June. Examination results are generally mailed to the graduate by September. The graduate is considered a certified medical assistant upon successful completion of this examination. Many physician-employers hire the medical assistant upon graduation, with the promise to increase her/his salary upon notification that the examination has been successfully completed.

So, how does a physician-employer secure one of these highly-trained individuals? Your best bet would be to call a coordinator from the accredited medical assisting program nearest your location (see names and telephone numbers below). This individual is usually in touch with graduates, or can forward information to the appropriate media. Triton College in River Grove, for example, offers a computerized job placement service. Graduates pay a nominal fee and are sent appropriate job descriptions. The physician-employer need only call (312) 456-0300, extensions 443 or 450, to list a position. There is no charge.

Four Illinois program coordinators can be reached by telephone. I can be contacted at Triton College, 2000 Fifth Avenue, River Grove, IL 60171; (312) 456-0300, ext. 293 or 438. At Harper College please ask for Vera Davis, R.N., CMA, Algonquin & Roselle Rds., Palatine, IL 60067; (312) 397-3000. At Belleville Area College the coordinator is Rose Hall, R.N., CMA-AC, 2500 Carlyle Ave., Belleville, IL 62221; (618) 235-2700, ext. 332. The Robert Morris coordinator is Judith Marshall, M.T., CMA-C, Carthage, IL 62321; (217) 357-2121.

A list of coordinators of accredited medical assisting programs in bordering states may be obtained from the AAMA at (312) 899-1500. Another way to secure qualified employees is to contact the Illinois Society of Medical Assistants' president, Mary Lu Ostrowski, CMA, at (309) 828-4504. She can provide the name of the local chapter president, who can forward the information at their monthly meeting. These meetings are generally attended by experienced medical assistants who may be in need of employment, or who can forward this information to qualified individuals who are seeking employment.

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 E. Jackson St., Bloomington 61701; Robin Bluestein, CMA-C, co-chairman, Public Relations Committee, 2247 W. Estes, #2, Chicago 60645 or Catherine M. Hill, CMA, co-chairman, Public Relations Committee, 900 S. Plum Grove Road, Palatine 60067.

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Evaluation of Acute Asthma in Children . . . 30



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Helping Impaired Physicians



When our critics keep telling us to "clean up our house," they are referring to our medical disciplinary system as well as the impaired or disabled physician problem. I prefer to separate these concepts because we are not out to discipline or punish the impaired physician—unless he or she refuses help—but rather to get them the help needed to make them productive members of our profession again.

What, exactly, is an impaired or disabled physician? Generally speaking, he or she is unable to practice medicine adequately because of psychiatric disorders, senility, alcoholism and/or drug dependency.

Not all impaired physicians come to the hospital in an intoxicated state or have drug-induced hallucinations or forget basic clinical skills. Some do, of course, and they need help. But all doctors who are impaired need help. And with some of them, the warning signs are not so obvious.

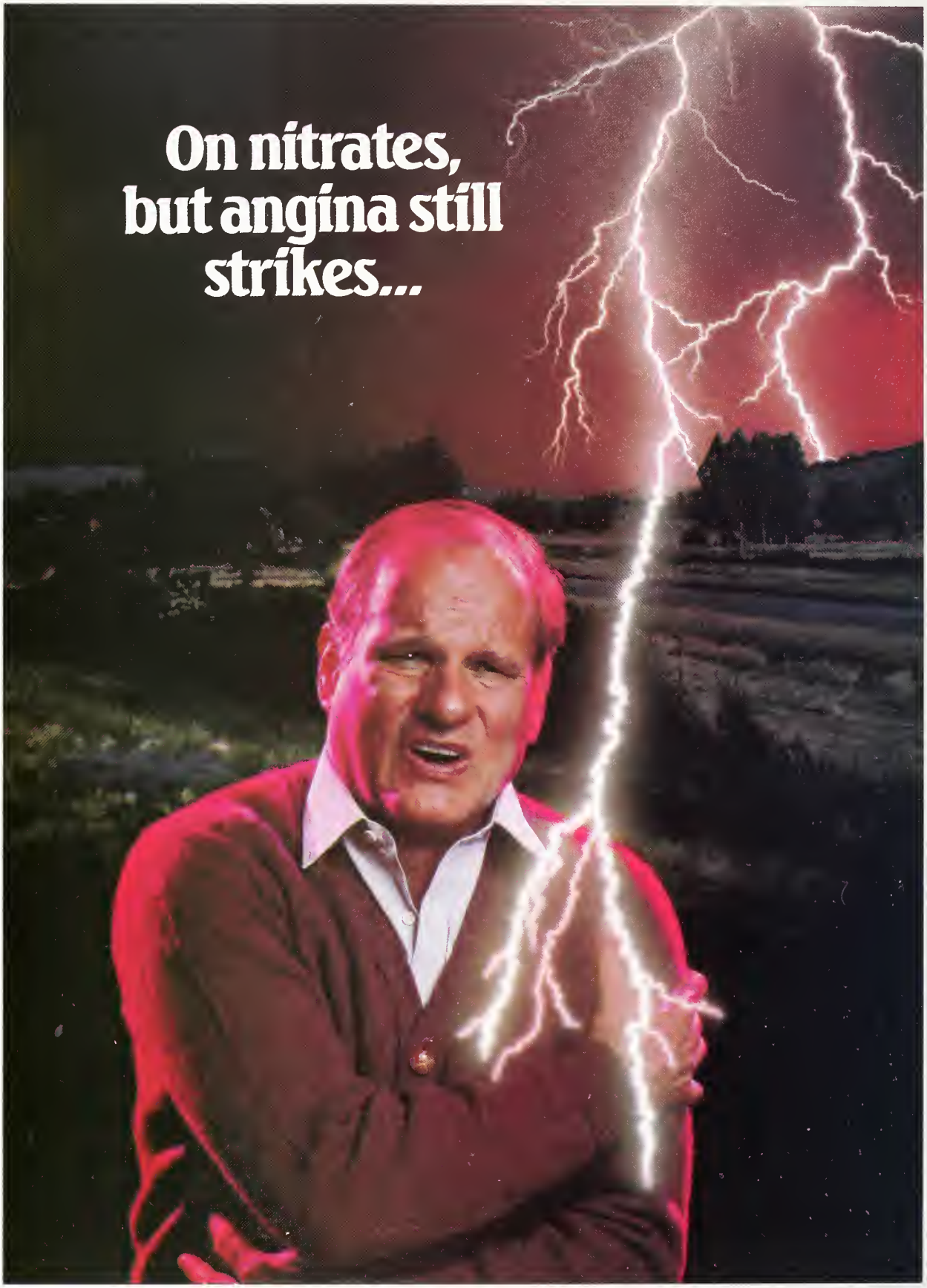
Last year, some of our county leaders held a meeting to try to come up with ideas on how we could assist hospital medical staffs in forming disabled physician panels. I was surprised when a significant number of physician leaders in the room stated that they had never seen or known of an impaired physician at their hospitals. It was then that I realized that this is not a conspiracy of silence, as some contend, but a lack of recognition.

Everyone can spot the physician who has been involved in a felony or who has had a major accident at the hospital. Fortunately, these incidents are rare. But it is much more difficult to spot the clever marginally impaired physician who may eventually cause a catastrophic situation or who may not be doing well in his other office practice. It is our duty to assist the impaired physician before there is a major incident.

The state medical society has had a committee to assist impaired physicians since 1977. Members of that committee and members of regional intervention teams are available to assist in local efforts and in specific local problems. They can be reached through the confidential Physician Help Line: 312-580-2499. But the fundamental step is to form a solid program at the local level.

Last year there was a concerted effort at the state and county level to form local disabled physician panels. ISMS prepared and sent out guidelines for the formation of committees to assist impaired physicians. We know of some positive things that have been done where panels have been formed. We do not know, however, if there is a complete network of panels over the state. If we are to keep the impaired physician from becoming a discipline problem, we need much activity at the local level to help these people. If there are any problems in setting up panels or in getting them to function, please let us know. ◀

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Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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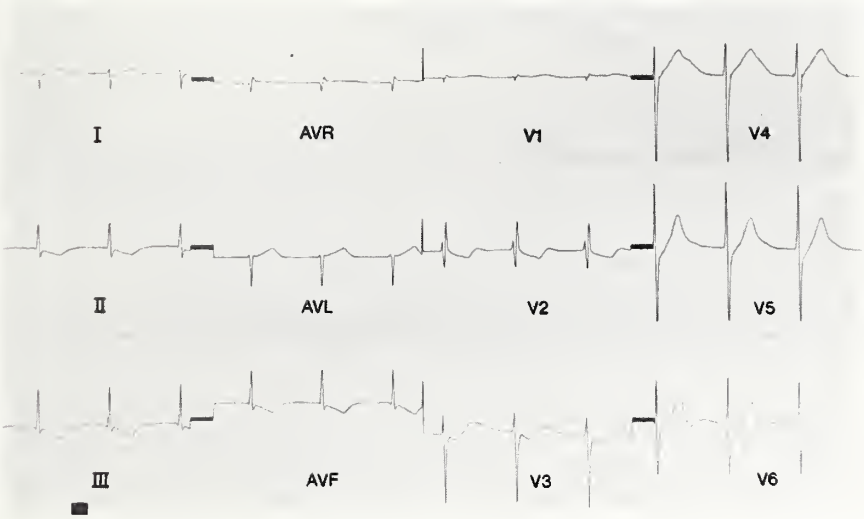
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This is a 56-year-old man with an eight month history of progressive dyspnea on exertion. He is now short of breath after walking only ten yards. He denies chest pain or ankle swelling. He smokes about 75 packages of cigarettes per year. History includes a deep vein thrombosis, right inguinal herniorrhaphy and bleeding gastric ulcer. His physical exam shows a blood pressure of 120/70mmHg and an irregularly irregular pulse rate of 80 beats per minute. There is good ventilation in the upper lung fields with bilateral basal crepitant rales. Cardiac exam shows an active point of maximum impulse outside the anterior axillary line. P2 is accentuated; first and second heart sounds are otherwise normal. There is a grade 3/6 pansystolic murmur at the apex with radiation into the axilla. An ECG rhythm strip shows atrial fibrillation with a controlled ventricular response. Cardiac catheterization and open heart surgery are performed. On the second postoperative day, this 12 lead ECG is obtained.

Questions:

1. The twelve lead ECG show(s):
   A. A pattern compatible with right ventricular hypertrophy and right axis deviation.
   B. An atrioventricular (AV) junctional rhythm.
   C. Atrial fibrillation with a moderate ventricular response.
   D. An acute anteroseptal myocardial infarction.
   E. An accelerated idioventricular rhythm.

2. Treatment of this patient could include:
   A. Continuation of maintenance digoxin.
   B. Treatment of chronic obstructive pulmonary disease.
   C. Addition of quinidine or procainamide.
   D. Addition of mexilitine, tocainide, or flecainide.
   E. Careful monitoring of the arrhythmia with watchful expectancy.

(Continued on page 18)

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The Wisdom of Children

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

I'm sure you won't be surprised to know that Mt. Hawley has its Village Idiot. Towns and villages would not be complete if they didn't have a recognized Village Idiot.

Makes me wonder why cities don't have city idiots—can it be that they are there but they run for public office? But I wander . . . Forgive me!!

Lawrence, the Mt Hawley V.I., became the topic of conversation among the street watchers at the Apollo Cafe. Lawrence had spent most of his non-working career collecting tin foil from wrappers, cigarette packages, gum wrappers, what have you. You probably remember how we did that as kids. Well Lawrence got so intrigued with that activity that he kept right on collecting until his ball of tin foil became truly gigantic. And, as this tin foil ball grew larger, the number of wrappers available became rarer.

This morning, then, the coffee-sipping observors were commenting on Lawrence's smarts—or the lack thereof—as he rolled the gigantic silver ball down Second Street, eyes searching the gutter, street and sidewalks for a wrapper with a glint of silver. "He must wear more silver off that ball as he rolls it then he can add to it with these meager pickings," offered Chic. "Lawrence never was noted for smarts," added Willard, "but doing that does keep him off the street, or maybe better said, out of trouble."

"You have to give Lawrence credit for basic good sense," it was Asa coming to the defense. "I asked him why he kept rolling that silver ball along when it would be easier to leave it, find and bring the wrapper to the ball. What Lawrence had figured out was that it was a lot easier to keep the ball rolling than it was to start it up again if he allowed it to stop."

The wisdom of children and V.I.s is sometimes so profound that it's scary, and it occurred to me that this had the moral impact of an Aesop's Fairy Tale—or in this instance, a Goodwin's Tail. Applicable too, to what you medical folks have done with malpractice legislation here in Illinois. You had a lot going, rolling right along gathering size and glitter as you went.

It's always a lot easier to get enthused for a short time effort, whether that's a Super Bowl, or a pep rally in Springfield. The difficulty is in keeping the drive going and the enthusiasm high. Frankly, as a sideline rooter, I'm a little concerned. From what I read now, some of you are complaining about your insurance company—about rates—about the folks on your side. If I was on the other side of the aisle on this issue—and I'm not—that's exactly what I would want and hope for.

Seems to me that now, of all times, you need to keep your eyes on the target—a tort system that needs reforms—and you need to keep your enthusiasm high, not get distracted and keep the ball rolling. Remember that it will be a lot harder to start up that ball if it comes to a standstill!!



Your servant,
E. Goodwin

THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Thomas Predey, M.D., Department of Radiology, Loyola University Medical Center, Maywood



Figure 1

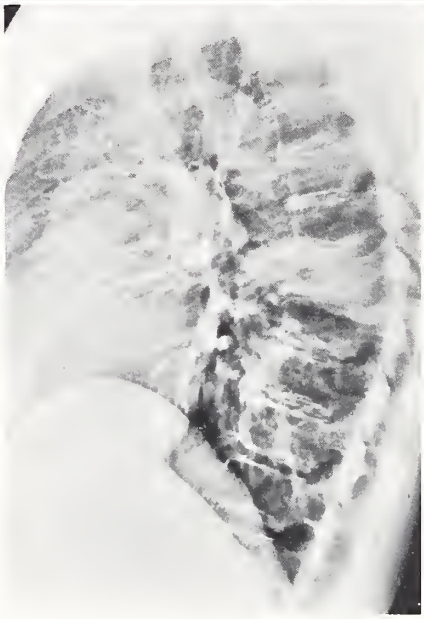


Figure 2

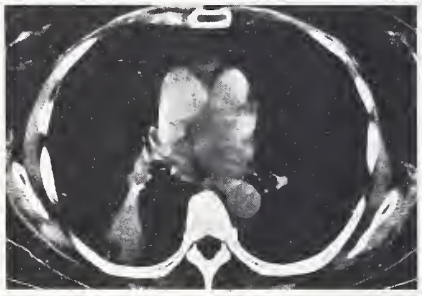


Figure 3

Case #1—A 63-year-old female with recurrent pneumonia in superior segment of right lower lobe. PA (Figure 1) and lateral (Figure 2) chest radiographs. Thoracic CT examination (Figure 3).



Figure 4

Case #2—A 66-year-old male with hemoptysis. Thoracic CT examination. (Plain chest radiographs not available).

Both patients have the same diagnosis.

What's your diagnosis?

A. Aspirated broken tooth
B. Endobronchial tumor
C. Broncholithiasis
D. Mucoid impaction

(Continued on page 37)



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OBITUARIES

****Gilmore, John H.,** Port Angeles, Washington, died June 2, 1986 at the age of 79. Dr. Gilmore was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

****Hallenbeck, George G.,** Oak Brook, died June 1, 1986 at the age of 84. Dr. Hallenbeck was a 1928 graduate of Rush Medical College, Chicago.

****Hatzis, Peter N.,** Chicago, died April 30, 1986 at the age of 83. Dr. Hatzis was a 1928 graduate of the University of Illinois College of Medicine, Chicago.

****Haupt, Leslie G.,** Chicago, died May 8, 1986 at the age of 87. Dr. Haupt was a 1923 graduate of the Fak der Universitat Wien, Wien, Austria.

***Hecht, Roy A.,** Altamonte Springs, Florida, (formerly of Kankakee) died April 28, 1986 at the age of 67. Dr. Hecht was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

***Katz, Josef,** Elk Grove Village, died May 3, 1986 at the age of 56. Dr. Katz was a 1956 graduate of the Faculte de Medecine de l'Universite de Geneve, Geneve, Switzerland.

***Robinson, Anna E. Isham,** Atlanta, Georgia, died March 17, 1986 at the age of 98. Dr. Robinson was a 1914 graduate of the University of Illinois College of Medicine, Chicago.

****Sill, Grant W.,** Pasadena, California, died April 20, 1986 at the age of 94. Dr. Sill was a 1919 graduate of the University of Illinois College of Medicine, Chicago.

****Tschetter, David J.,** Greenville, North Carolina, died in April, 1986, at the age of 80. Dr. Tschetter was a 1936 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

***Urban, Rudolph J.,** Pekin, died April 17, 1986 at the age of 61. Dr. Urban was a 1950 graduate of Orvosi Fakultas Tudomanyegyetem, Budapest, Hungary.

***Walls, Clarence E.,** Oak Park, died June 1, 1986 at the age of 76. Dr. Walls was a 1942 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Weil, Jerome J.,** Ft. Lauderdale, Florida, died May 8, 1986 at the age of 93. Dr. Weil was a 1913 graduate of the University of Illinois College of Medicine, Chicago.

****Wittelle, Frank M.,** Crown Point, Indiana, died May 5, 1986 at the age of 90. Dr. Wittelle was a 1920 graduate of the University of Illinois College of Medicine, Chicago.

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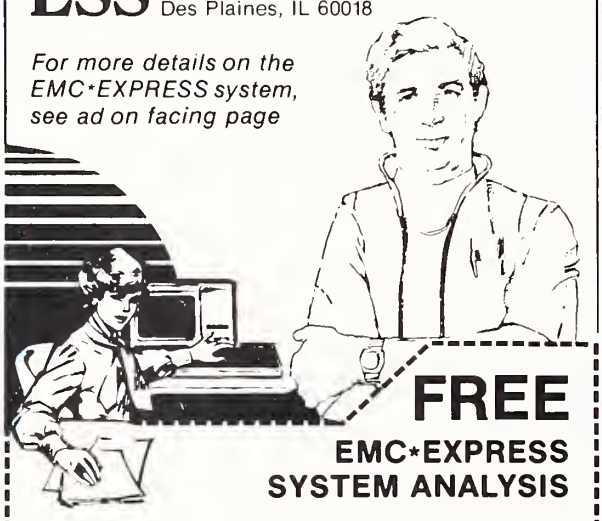
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EKG

(Continued from page 9)

Answers: 1. A, B 2. E

The twelve lead ECG shows a regular rhythm with beats that have a normal QRS duration at a rate of 72 beats per minute. The QRS axis is rightward in the frontal plane to +115°. The right axis deviation with deep S waves in leads V_5 and V_6 and an RSR′ pattern in lead V_2 suggest right ventricular hypertrophy. This was the same QRS pattern the patient demonstrated preoperatively. There are no P waves present and the rhythm is regular. This is an AV junctional rhythm that is slightly accelerated. In this tracing it is difficult to define the atrial rhythm, but it is no longer atrial fibrillation conducting to the ventricles in an irregularly irregular pattern. If atrial fibrillation is present, there is also complete AV dissociation with an AV junctional pacemaker now taking over.

This is a postoperative arrhythmia that was well tolerated by the patient. At the time of cardiac catheterization, the patient complained of dyspnea. The pulmonary artery pressure was 80/30mmHg with a mean pulmonary capillary wedge pressure of 40mmHg. There was severe mitral regurgitation and a calcified mitral annulus. The left ventricle was enlarged and the coronary arteries showed non-obstructive plaques. Open heart surgery with mitral valve replacement was performed. Postoperative ECGs showed the AV junctional rhythm.

Supraventricular arrhythmias are common, reported in 37 of 50 patients in the series by Smith, *et al.*[1] In this report, AV junctional rhythm was second in incidence to atrial fibrillation in the postoperative period. In another series by Chee, *et al.*, all 41 patients undergoing valvular surgery had postoperative supraventricular arrhythmias.[2] Most of these arrhythmias will respond to digoxin.[2]

We elected to monitor the patient without drug therapy. Any of the drugs listed could have slowed or suppressed the AV junctional pacemaker. On postoperative day six, atrial fibrillation returned and the ventricular response increased. Maintenance digoxin was then resumed.

References

1. Smith, Roger, *et al.*: "Arrhythmias Following Cardiac Valve Replacement," *Circulation* 45:1018-1023, 1972.
2. Chee, T. P., *et al.*: "Postoperative Supraventricular Arrhythmias and the Role of Prophylactic Digoxin in Cardiac Surgery," *Amer Heart J* 104:974-977, 1982.

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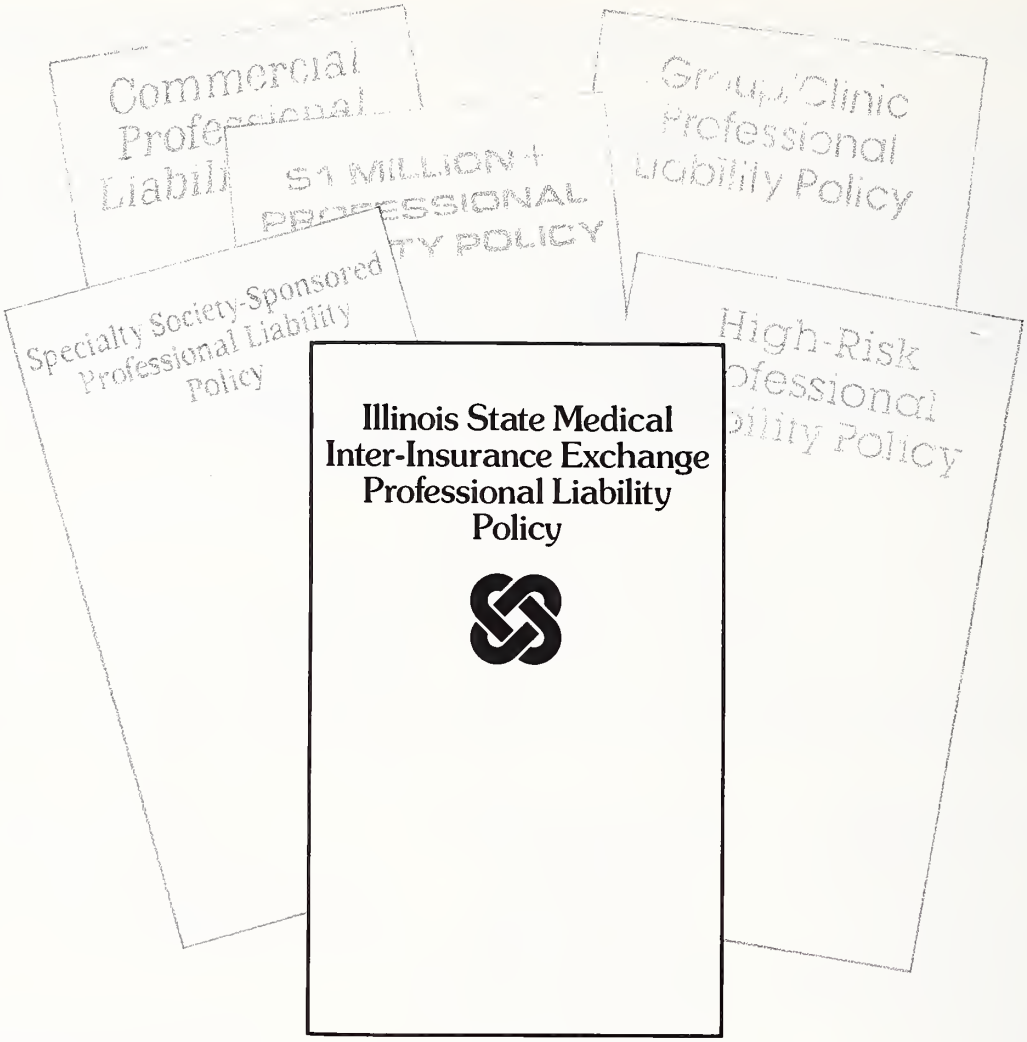
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Volume 170, No. 1
July 1986

A Regional Program

Neonatal Follow-Up

By Howard S. Cohen, M.D. and Andrew M. Morgan, M.D./Peoria

A comprehensive program for neurodevelopmental follow-up of at-risk neonates is described. This multidisciplinary, regionally based program in a rural area emphasizes interaction of primary health care providers with tertiary center personnel. Children are evaluated and receive services close to their homes at no direct cost to their families. The program appears to be well accepted by the region's primary care providers, and might be a model for other perinatal regions which seek to develop follow-up projects.

Regional perinatal centers identify newborns at risk for neurodevelopmental problems and provide follow-up in order to assure prompt diagnosis and therapy. In 1983, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, published perinatal care guidelines which specified requirements beyond those for normal neonates. These included systematic detailed examination for physical or psychological problems. They stressed follow-up programs, both for research and for "early identification, intervention, support, stimulation, training and education." The guidelines noted that follow-up programs are well suited to screen the at-risk population and called for appropriate referral of specific neurodevelopmental or neurosensory problems.[1]

Other centers have described their follow-up projects.[2-6] This paper describes the program developed in the North Central Illinois Perinatal Region. This project involves all regional high risk pregnancies and babies cared for at the North Central Illinois Perinatal Center, and includes the entire "perinatal denominator" by identifying regional patients who may have received their care at one of the other Illinois centers. It interrelates perinatal center specialists with numerous other professionals who also see these children, emphasizing the advocacy role of each child's primary health care providers in an ongoing multidisciplinary system of neurodevelopmental evaluation and care. We hope that it can serve as a model for other rural perinatal programs as they are developed.

Methods

The North Central Illinois Perinatal Region encompasses 24 counties in central Illinois. (Figure 1) It includes 29 Level I and Level II hospitals and the Tertiary Care Center at Saint Francis Medical Center in Peoria. There are 19,000 births in the region annually, about 700 of which are admitted to the perinatal center for care.

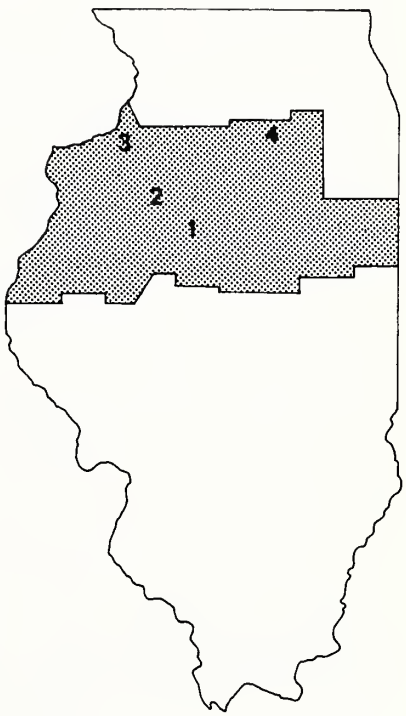


Figure 1
North Central Illinois Perinatal Region (gray area). Follow-up sites: 1 = Peoria, 2 = Galesburg, 3 = Rock Island-Moline, 4 = Ottawa.

TABLE 1
Criteria for High Risk Follow-Up

1. Less than 1500g birthweight
2. Ventilator therapy
3. Asphyxia neonatorum (five minute apgar <7)
4. Seizures
5. Meningitis
6. Hyperbilirubinemia requiring exchange transfusion
7. Prolonged hypotonia

TABLE 2
Criteria for Moderate Risk Follow-Up

Admission to the Intensive Care Nursery and:

1. Respiratory illness not requiring ventilator therapy
2. Sepsis
3. Congenital anomalies
4. Hyperbilirubinemia, not needing exchange
5. Low birthweight (1501-1814g)
6. Hypoglycemia
7. Intrauterine viral infections
8. Maternal diabetes

The intensity of follow-up is defined by the perceived risk. Specific criteria determine whether neonates requiring tertiary care are at moderate or high risk for neurodevelopmental abnormality. (Tables 1, 2)

Moderate risk infants are screened developmentally and neurologically by their primary care physician at routine well baby visits. They also undergo neurodevelopmental screening by public health nurses during state-mandated visits at 6, 12, 18, 24 and 36 months. A screening tool developed by the project is used to evaluate fine and gross motor function, expressive and receptive language, and abnormal motor patterns during infancy. Children failing the screen are referred to their primary care physician, or, with his or her consent, to the Regional Developmental Follow-up Project for further evaluation.

TABLE 3
Schedule of Follow-Up Visits for High Risk Children

4-6 months
History and physical exam
Neurological exam
Peabody Motor Assessment
Hearing screen

10-12 months
History and physical exam
Neurological exam
Peabody Motor Assessment

18 months
History and physical exam
Neurological exam
Bayley Scale of Mental Development
Peabody Motor Assessment

30 months
History and physical exam
Neurological exam
Peabody Motor Assessment
Stanford-Binet Intelligence Scale

5-6 years
History and physical exam
Neurological exam
Peabody Motor Assessment
WPPSI

7-8 years
History and physical exam
Neurological exam
Peabody Motor Assessment
WISC-R

High risk infants, in addition to neurodevelopmental screening by both their primary care physician and public health nurse, are followed periodically in the Regional Developmental Follow-up Project (RDFP). The project's base clinic site is in Peoria with satellite sites in Galesburg, Rock Island-Moline, and Ottawa. Each month in addition to two or three full-day clinics held in Peoria, core members of the follow-up team travel to one of the satellites. Follow-up teams are composed of a developmental pediatrician, neonatologist, psychologist/coordinator, occupational therapist and physical therapist.

At each site, a coordinator from the local developmental agency helps to arrange appointments and make referrals. Fifteen to 20 children are seen during each clinic; each visit lasts 60-90 minutes. Timing of visits and tests administered are listed in Table 3.

A staffing is held after each evaluation. Cognitive and motor skills are determined to be normal, suspect, or abnormal, according to criteria in Table 4. Referral for other neurodevelopmental services is made only after telephone discussion with the child's primary care physician. Referrals are made within the child's community whenever possible. Medical problems requiring treatment are referred to the child's physician, who also receives a copy of the written evaluation by mail. One of the project physicians then meets with the family to explain findings and recommendations.

Families of high risk children who are lost to follow-up at 18 months are interviewed by telephone in order to determine the child's neurodevelopmental status at that time. Age-appropriate screening questions are asked, as well as inquiries into specific developmental diagnoses and services the child is receiving.

The project has provided education for a variety of health care professionals. This includes medical students, pediatric house officers, nurse clinicians, community nurses, therapists, psychologists, educators, nursing students, and social workers. A group of community physicians participated in a ten-week training fellowship and now serve as medical liaisons at each clinic site.

The project's research potential has been explained in several studies involving perinatal care. These include: the use of indometh-

TABLE 4
Definition of Outcome Categories

Motor	Cognitive
Normal = normal neurological exam + developmental age appropriate motor skills	Normal = developmental age appropriate skills in all areas: fine and gross motor, receptive and expressive language, perceptual performance. (D.Q. > 80)
Suspect or mildly abnormal = abnormal neurological findings + developmental age motor skills 1-2 S.D. below the mean.	Suspect or mildly abnormal = developmental age skills 1-2 S.D. below the mean. (D.Q. > 69 < 80)
Abnormal = abnormal neurological findings + developmental age motor skills >2 S.D. below the mean. Includes children with neurological diagnoses, *e.g.*, cerebral palsey.	Abnormal = developmental age skills >2 S.D. below the mean. (D.Q. ≤ 69)

Children are classified as (1) normal, both in motor and cognitive function, (2) suspect, in either or both motor and/or cognitive function, or (3) abnormal, in either motor and/or cognitive function.

TABLE 5
Results for High Risk Children (18 Months' Developmental Age)

Number of children enrolled and discharged—312:	
Post hospital discharge deaths	17
Lost to follow-up	25
Seen at 18 months	174
Seen earlier and telephone data at 18 months	20
Telephone data only at 18 months	76
Total with neurodevelopmental data at 18 months—270:	
Normal	186
Suspect	39
Abnormal	45

acin to prevent intracranial hemorrhage; iatrogenic Respiratory Distress Syndrome; the National Collaborative Meningitis Study; relationship of neonatal apnea to outcome; and the effect of neonatal and maternal transport on outcome of very low birthweight infants. Since the project includes all regional births rather than just perinatal center admissions, our data allows for meaningful evaluation of the quality of the region's perinatal care, and education by inclusion of the entire perinatal denominator.[7]

Funding

The RDFP is funded through several grants, in addition to donations of time and space by various institutions and agencies. (See acknowledgement) This has allowed the evaluations to be completed at no cost to families.

Results

In the first two years of the RDFP, 312 high risk children reached 18 months' developmental age. Of these, 174 have been evaluated sequentially, 76 screened by telephone interview, and 17 have died. Only 8% (25 children) were lost to follow-up. Of those children seen, 17% were abnormal, 14% suspect and 69% normal. (Table 5) Approximately 30% of those children have been referred to other agencies for further evaluation and care. These percentages are similar to those others have reported, and clearly justify the need for projects such as this.[4,5,8-12]

During 1982-83, 56 moderate risk children were referred to the RDFP for further neurodevelopmental evaluation. Fifty percent were considered abnormal and in need of further therapy. This confirms the usefulness of office or public health screening to identify abnormalities in moderate risk children.

Recently, 320 primary care physicians in the region were surveyed to evaluate satisfaction with the project. One hundred and sixty responses (50%) were received with only five unfavorable comments. This appears to indicate overall physician satisfaction with the project.

Conclusion

A comprehensive program for neurodevelopmental follow-up of children born in the North-Central Illinois region has been established. This multidisciplinary, regionally-based program emphasizes the active interaction of primary health care providers with tertiary care personnel, and operates at no direct cost to families. Children at neurodevelopmental risk are identified, evaluated periodically, and when necessary, referred for services, usually close to their homes. Additionally, the program appears to be well-accepted by the region's primary care providers. We believe that this program can serve as a model for other perinatal regions as they develop follow-up projects. ◀

References

1. "Guidelines for Perinatal Care," American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 99-104, 1983.
2. Saigal, S.: "Outcome in Infants 501 to 1000gm Birth Weight Delivered to Residents of the McMaster Health Region," *J Pediatr* 105:969, 1984.
3. Walentik, C.: "A Multidisciplinary Team Approach to NICU 'Graduate' Follow-up," *Perinatology-Neonatology* 6:49, 1982.
4. Kitchen, W.: "Outcome in Infants with Birthweight 500-999gms; A Regional Study of 1979 and 1980 Births," *J Pediatr* 104:921, 1984.
5. Wingert, W.A.: "PNPs in Follow-Up Care of High Risk Infants,"

American Journal of Nursing 80:1485, 1980.
6. Liden, C.B.: "TRANSACT—A Model for Integrating Clinical Practice and Longitudinal Research," *Seminars in Perinatology* 6:340, 1982.
7. Miller, T.C.: "Maternal Transport and the Perinatal Denominator," *Am J Obstet and Gynecol* 147:19, 1983.
8. "Neonatal Neurological Assessment and Outcome," Report of the Seventy-Seventh Ross Conference on Pediatric Research. Dec., 1978.
9. Johnson, J.D.: "Prognosis of Children Surviving with the Aid of Mechanical Ventilation in the Newborn Period," *J Pediatr* 84:272, 1974.
10. Kitchen, W.H.: "Collaborative Study of Very Low Birthweight Infants: Outcome of Two Year-Old Survivors," *Lancet* 1:1457, 1982.
11. Dinwiddie, R.: "Quality of Survival After Artificial Ventilation of the Newborn," *Arch Dis Child* 49:703, 1974.
12. Kiely, J.L.: "Cerebral Palsy and Newborn Care. II: Mortality and Neurological Impairment in Low Birthweight Infants," *Developmental Medicine and Child Neurology* 23:650, 1981.

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A Sequela of Empyema

Primary Squamous Cell Carcinoma of Pleura

By Dilip D. Dharkar, M.D., Bernard J. Leininger, M.D. and Joseph R. Kraft, M.D./Chicago

Squamous cell carcinoma in a chronic, long standing empyema cavity is described. The interval between development of empyema and onset of carcinoma was 12 years. Histogenesis may have been rooted in malignant transformation of metaplastic squamous epithelium in pleura. Alternatively, it might be traced to ingrowth of surface epithelium along the fistulous tract draining the empyema cavity to the skin surface with eventual malignant transformation.

Malignant change in a chronic empyema cavity is very rare. In fact, if mesotheliomas are excluded, other primary malignant tumors occuring in pleura are exceptional.

Malignant change has been reported in chronic draining cutaneous sinuses, fistulous tracts, pilonidal sinuses and vesicovaginal fistulae.[1-5] However, at this writing only 13 cases of malignant change in empyema cavity have been described in the literature.[2,5-8]

A case of squamous cell carcinoma in the pleura, in a patient with long standing, draining empyema, prompted this report.

The patient was a 64-year-old male who had developed a bronchopleural fistula followed by empyema and draining fistulae to the skin surface 12 years before. He had undergone surgery to drain the empyema cavity twice and Eloesser flaps had been fashioned for continuous drainage of the contents of the empyema cavity through the chest wall.

History included pulmonary tuberculosis contracted 45 years before as an adolescent in his native Greece. Treatment had consisted of olive oil instilled in the right pleural space (oleothorax) to induce pulmonary collapse.

Several years ago, he had developed active bleeding through the skin stoma and had experienced episodes of severe chest pain for a duration of two to three months. At this time, the patient again had surgery. Tissue from empyema cavity was sent for frozen section diagnosis and revealed squamous cell carcinoma. The fistulous tract was closed, and extrapleural pneumonectomy with resection of the posterior

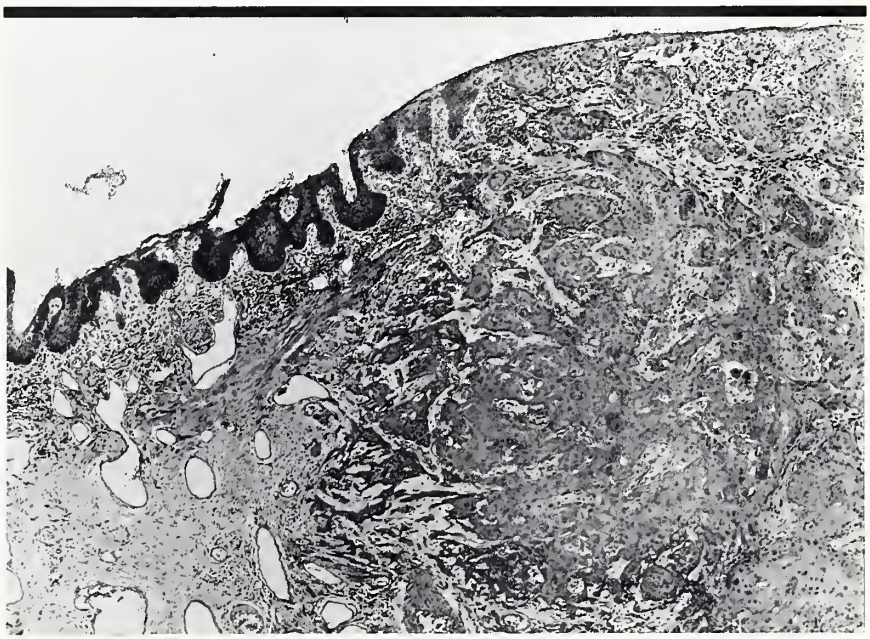


Figure 1: Epidermization of pleura is seen with malignant transformation into well-differentiated infiltrating squamous cell carcinoma.

portion of the chest wall and reconstruction of the chest wall were performed.

The patient tolerated the procedure very well. However, on the fourth post-operative day he had a sudden episode of ventricular fibrillation. Resuscitative measures were unsuccessful. Permission for an autopsy was not given.

Discussion

Malignant change has been noted in chronic, long standing, draining sinuses, fistulous tracts, pilonidal sinuses, vesico-vaginal fistulae and osteomyelitic sinuses.[1-5]

However, malignant transformation of the pleura in the empyema cavity is exceptional, and malignant transformation of the pleura into squamous cell carcinoma is, indeed, very rare. This is particularly striking, given the countless number of chronic empyema cases all around the world. On reviewing the world literature, we came across only 13 previous reports of this event.[2,5-8]

The patient had a history of pulmonary tuberculosis, for which one of the treatments offered was collapse of the lung with instillation of olive oil in the pleural cavity. Subsequent to this, the patient developed empyema, followed by a draining cutaneous fistula. Of the 13 cases reported in the literature, seven had pulmonary tuberculosis followed by empyema. In some of these, air had been introduced into the pleural cavity,[6,8] and pulmonary collapse had resulted.

Our patient had a draining cutaneous fistula and, later, Eloesser flaps were fashioned to facilitate drainage of the empyema. Of the other cases, five had draining cutaneous fistulae.[2,5,7,8]

In our case, the period between first appearance of empyema and detection of malignancy was 12 years. The other cases reported in the literature had intervals ranging from eight to 44 years.

The common denominator in all the cases reported in the literature, and in our case, has been a chronic, long standing empyema. Draining cutaneous fistulae may or may not be present. Many of the cases, however, did have a draining cutaneous fistula.[2,5,7,8] The time interval between the occurrence of empyema and detection of squamous carcinoma is also worth noting. Malignant change occurred after the empyema had been present anywhere from eight to 44 years. (Table 1)

TABLE 1
Cases of Primary Squamous Cell Carcinoma of Pleura Following Long Standing Empyema

REPORTED BY	YEAR	NO. OF CASES	LATENT PERIOD BETWEEN EMPYEMA AND CARCINOMA DETECTION (IN YEARS)	DRAINING CUTANEOUS FISTULA
Schmid[5]	1936	1	19	Present
McAnally & Dockerty[5]	1949	1	27	Absent
Peabody[2]	1960	1	11	Absent
Bruce *et. al.*[6]	1960	5	8-21	Absent
Deaton[2]	1962	1	23	Present
Ender[8]	1966	1	17	Present
Cattaneo & Klassen[7] (1973)	1973		44	Present
Ruttner & Heinzl[8]	1977	2	25 & 30	Present in one-absent in the other
Dharkar *et. al.* (present case report)	1985	1	12	Present-Eloesser flap fashioned

It is clear that malignant change can occur, albeit rarely, in a chronic, long standing empyema cavity with or without draining cutaneous fistulae.

One can only speculate as to the histogenesis of the malignant change, especially of squamous cell carcinoma in the pleura. The pleura normally consists of fibro-elastic membrane with lining mesothelial cells,[9] and has no squamous epithe-

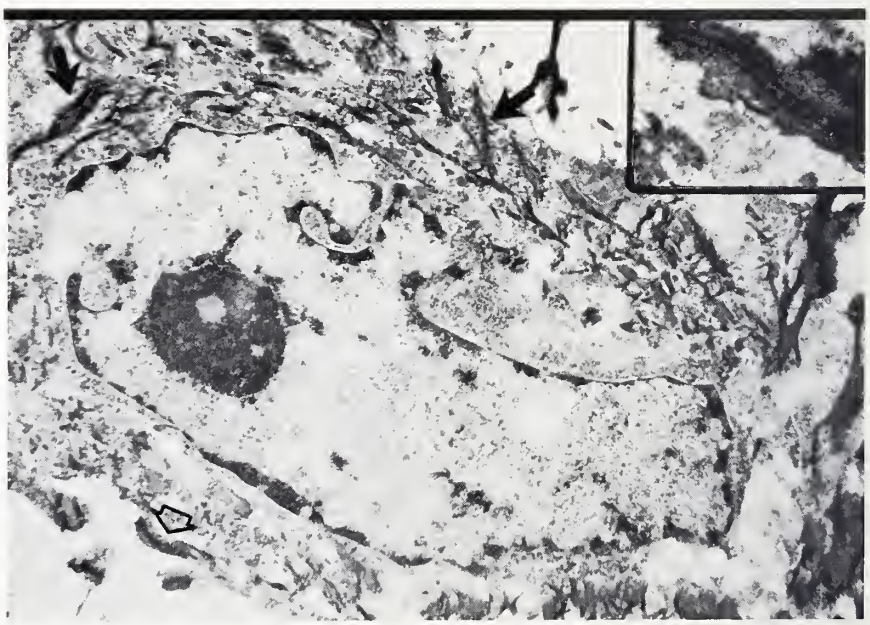


Figure 2: Electron micrograph showing tumor cell with desmosomes (open arrow) and tonofilaments (dark arrows). Inset reveals a desmosome at higher magnification.

lial lining. Ender and Merlier and Orcel[10] have shown that squamous epithelial metaplasia of pleural mesothelial cells in chronically irritated and inflamed pleura can occur. It is conceivable that this metaplastic tissue can undergo malignant transformation at a later date. The cases reported by Deaton[2] and Ender[8] showed this course of events. In our case also, we found squamous epithelium lining the pleura, (epidermization of pleura) from which a carcinoma was seen to arise. (Figure 1)

Modern immunohistochemical techniques have demonstrated that mesothelial cells do contain prekeratin in a distribution different from squamous and glandular epithelial cells. This fact is now used by pathologists to distinguish mesothelioma from squamous cell carcinoma and adenocarcinoma.[11,12] The step from keratin-containing mesothelial cells to keratinizing squamous cell carcinoma is not difficult in concept, even though it does not happen very frequently. A pleural malignancy with squamous characteristics probably represents an experiment by nature. In addition, metaplasia of different types of epithelia into squamous epithelium is a well known fact. It is not at all unthinkable that the mesothelium, which contains the basic ingredients of pre-keratin and cytokeratin, might transform into keratin-producing squamous cells showing ultrastructural tonofilaments.

The other theory is that, in cases where there is a draining cutaneous fistula with a fistulous tract, ingrowth of cutaneous surface epithelium could occur. This, in turn, could undergo malignant transformation. In our case this is a distinct possibility because the Eloessar flaps were fashioned to facilitate drainage. However, not all cases of carcinoma developing in empyema cavities have had draining fistulous tracts present. (Table 1).

Conclusion

Chronic, long-standing empyema with or without draining cutaneous fistulae can develop into squamous cell carcinoma. We present two theories as to the pathogenesis. The first is that they develop from squamous metaplastic changes in mesothelium and their subsequent malignant transformation. The second is that they develop from ingrowth of surface cutaneous epithelium via draining cutaneous fistulae and their subsequent malignant transformation. The third is that the process is an outgrowth of a combination of both etiologies. ◀

References

1. Brown, H.W., Rivera, J.: "Epidermoid Carcinoma Arising in a Pilonidal Sinus. Report of a Case and Review of the Literature," *Int Surg* 50:435-440, 1968.
2. Deaton, R.W.: "Carcinoma Arising in Chronic Empyema Cavity. Case Report with Review of the Literature," *Dis Chest* 42:563-566, 1962.
3. Horn, C.V., Templeton, A.C.: "Carcinoma Developing in a Drainage Sinus of Chronic Osteomyelitis of the Humerus," *Br J Surg* 58:399-400, 1971.
4. Hudson, C.N.: "Malignant Change in an Obstetric Vesicovaginal Fistula," *Proc Roy Soc Med* 61:1280-1281, 1968.
5. McAnally, A.K., and Dockerty, M.B.: "Carcinoma Developing in Chronic Draining Cutaneous Sinuses and Fistulas," *Surg Gynecol and Obstet* 88:87-96, 1949.
6. Bruce, T., Dahlstrom, G., Uggla, L.B.: "Squamous Epithelial Cancer of the Pleura Following Extrapleural Pneumothorax for Pulmonary Tuberculosis," *Acta Tuberc Scand* 38:261-266, 1960.
7. Cattaneo, S.M., Klassen, K.P.: "Carcinoma of the Chest Wall Complicating Chronically Draining Empyema," *Chest* 64:673-674, 1973.
8. Ruttner, J.R., Heinzl, S.: "Squamous Cell Carcinoma of the Pleura," *Thorax* 32:497-500, 1977.
9. Ham, A.W., Cormack, D.W.: HISTOLOGY, 8th. edition, J.B. Lippincott, Philadelphia, 1979, p. 725.
10. Merlier, M., Orcel, L.: "Pachypleurite Chronique Avec Revetement Epithelial des Deux Feuillets de Pleure. La Semaine des Hospitaux de Paris." *Arch D' Anat Path (Par)* 32:127-128, 1956.
11. Kahn, H.J., Hanna, W., Yeger, H., Baumal, R.: Immunohistochemical Localization of Pre-Keratin Filaments in Benign and Malignant Cells in Effusions," *Am J Pathol* 109:206-214, 1982.
12. Schlegel, R., Banks-Schlegel, S., McLeod, J.A., Pinkus, G.S.: "Immunoperoxidase Localization of Keratin in Human Neoplasms: A Preliminary Survey," *Am J Pathol* 101:41-49, 1980.

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Correlation in Acute Childhood Asthma

Clinical Assessment Score and Peak Expiratory Flow Rate

By Margaret Strub, M.D., Charles Frey, Jr., D.O., Steven Waskerwitz, M.D., Susan Unfer, M.D., Allan T. Luskin, M.D., and David S. Chudwin, M.D./Chicago

Asthma is a major cause of hospitalization and morbidity in children. It is the most common chronic illness of childhood, as well as the most common admitting diagnosis in the pediatric age group.[1] The prevalence of pediatric asthma and related diseases in children is estimated to be 5%-10%.

Judging severity of illness is a major dilemma in acute bronchial asthma, especially in an emergency room setting. At initial observation, it is often difficult to assess the degree of pulmonary impairment, particularly in young children.

Studies of adults have emphasized spirometry testing as an important predictor of severity and the need for hospitalization.[2-6] In children, however, it is often technically difficult to obtain these effort-dependent measurements.

This study sought to determine whether an easily obtainable clinical assessment score (CAS)[7] correlated with pulmonary function testing, specifically, peak expiratory flow rate (PF), in children with acute asthma.

Fifty acute asthmatic children, aged 6-17 years, were evaluated at presentation to a pediatric emergency room in a major urban medical center. Criteria for inclusion were active wheezing and at least one previous episode of wheezing. Emergency room physicians performed the assessments.

A clinical assessment score (CAS) was determined. Five clinical characteristics (skin color, accessory muscle use, wheezing, air exchange and mental status) were rated with a score of 0-2.[7] These scores were determined twice, on initial evaluation in the emergency room, and at the time of discharge, either home or to the hospital.

Peak flow (PF) measurements were obtained on presentation and again at discharge using a flow meter. PF determinations were done three times and the highest value was used. PF measurements were expressed as percent normal for height, using the formula $-379.17 + (4.90 \times \text{height in cm})$ as the normal value for height.[8]

Linear regression analysis was used to determine the correlation between CAS and PF.

Results

Despite coaching, reliable PF measurements could not be obtained in 18 of the 50 children. Another eight patients could not be evaluated because accurate heights, necessary to standardize PF measurements, were not obtained. The 24 remaining patients included 13 males and 11 females, with ten in the 6-9 year range, eight in the 10-13 year range, and six in the 14-17 year range. Precipitating factors, multiple in some patients, for the acute exacerbations of asthma, were: upper respiratory infection (URI) (71%), change in weather (29%), allergic exposure (17%), emotional upset (13%), inhaled irritant (13%) and exercise (9%). Theophylline levels were obtained on eleven of the children: ten were in the subtherapeutic range and eight of these levels were less than five

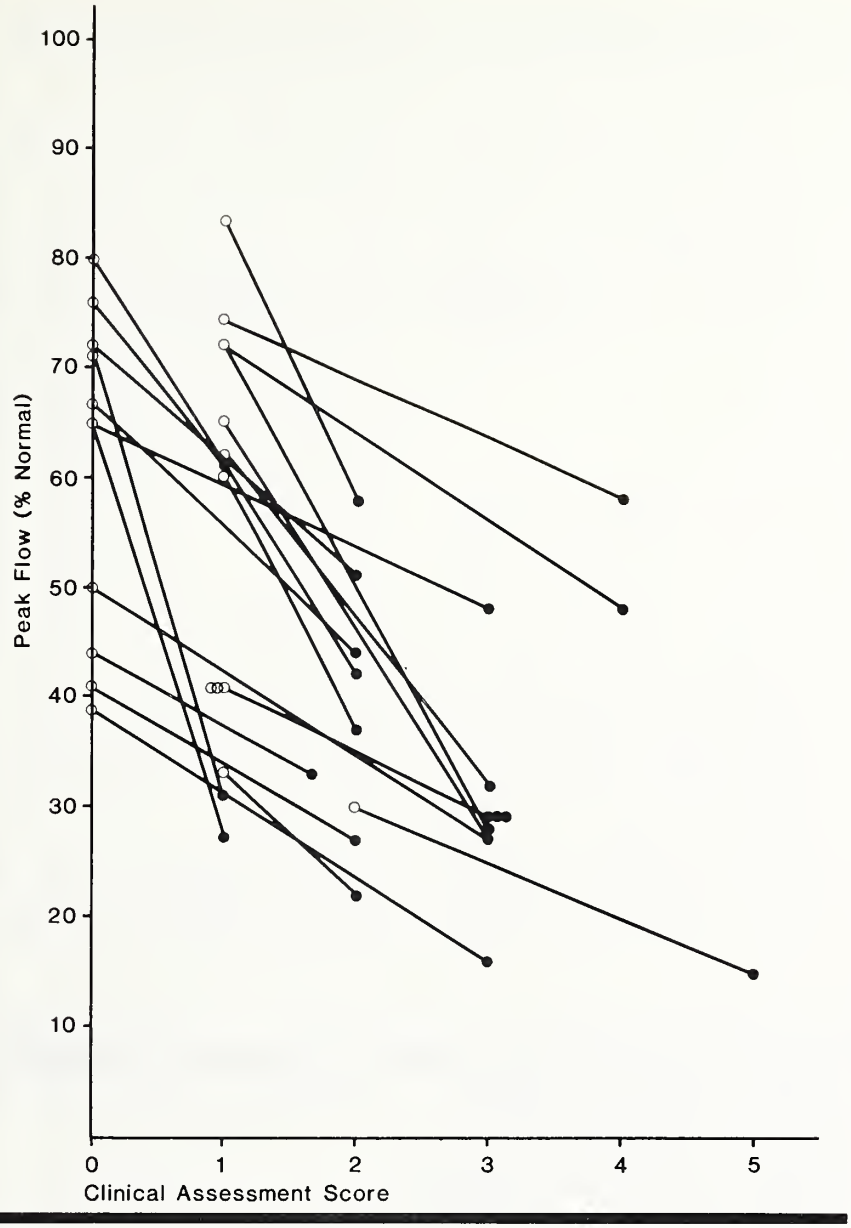


Figure 1.
Clinical assessment scores negatively correlate with peak flow. Clinical assessment scores are plotted on the abscissa, with higher scores representing more severely affected patients. Peak flows, expressed as percent normal for height, are plotted on the ordinate. Each line represents data from a single patient on admission (closed circles) and discharge (open circles) from the emergency room.

μg/ml. All reportedly had taken their medications.

A significant negative correlation ($p < .001$) was found between CAS and PF. In Figure 1, CAS is plotted against the corrected peak flow (percent normal for height). Each line represents data obtained on a single patient on admission and on discharge from the emergency room.

Discussion

Reliable pulmonary function measurements can be difficult to obtain in children, even a relatively simple parameter such as PF. Moderate cooperation is required as the measurement is effort-dependent. Standards are required, as PF must be expressed as a percent normal for height. CAS, however, is readily obtained. No equipment is required and no cooperation is needed because the score is effort-independent.

Previously, Nowak and colleagues reported that either PF or FEV_1 measurements could predict which patients would require hospitalization for acute asthma.[9] Fischl and co-workers included PF with a combination of physical findings and developed a score which could predict the need for admission in adults with asthma.[10,11] Becker and others showed that a clinical pulmonary index correlated with spirometry.[12] Our study demonstrated a significant negative correlation between a simple CAS and PF. Those patients with higher CAS had lower PF values and were more severely affected.

In conclusion, 50 children with acute asthma were evaluated prospectively on presentation to an emergency room. Of these, 18 were excluded because they were unable to perform a reliable peak flow determination. An additional eight were excluded because reliable height measurements had not been obtained. In the remaining 24 children, aged 6-17 years, a clinical assessment score[7] significantly correlated with peak expiratory flow measurements. This clinical assessment score (based on skin color, accessory muscle usage, wheezing, air exchange, and mental status) may be useful in determining the severity of asthma in children. ◀

References

1. Ellis, E.F.: "Asthma in Childhood," *J Allergy Clin Immunol* 72:526-539, 1983.
2. Brandstetter, R.D., Gotz, V.P., Mar, D.D.: "Identifying the Acutely Ill Patient with Asthma," *Southern Med J* 74:713-15, 1981.
3. Eliakim, R., Halperin, Y., Menczel, J.: "A Predictor Index for Hospitalization for Patients with Acute Asthmatic Attacks," *Israel J Med Sci* 20:202-6, 1984.
4. Nowak, R.M., Gordon, K.R., Wroblewski, D.A., Tomlanovich, M.C., Kvale, P.A.: "Spirometric Evaluation of Acute Bronchial Asthma," *JACEP* 8:9-12, 1979.
5. Martin, T.G., Elenbaas, R.M., Pingleton, S.H.: "Use of Peak Expiratory Flow Rates to Eliminate

Unnecessary Arterial Blood Gases in Acute Asthma," *Ann Emergency Med* 11:70-73, 1982.
6. Nowak, R.M., Tomlanovich, M.C., Sarkar, D.D., Kvale, P.A., Anderson, J.A.: "Arterial Blood Gases and Pulmonary Function Testing in Acute Bronchial Asthma," *JAMA* 249:2043-6, 1983.
7. Wood, D.W., Downes, J.J., Lecks, H.I.: "A Clinical Scoring System for the Diagnosis of Respiratory Failure," *AJDC* 123:227, 1972.
8. Weng, Levison: "Pulmonary Function Standards," *Am Rev Resp Dis* 99:879, 1969.
9. Nowak, R.M., Pensier, M.K., Sarkar, D.D., Anderson, J.A., Kvale, P.A., Ortiz, A.E., Tomlanovich, M.C.: "Comparison of Peak Expiratory Flow and FEV_1 Admission Criteria for Acute Bronchial Asthma," *Ann Emergency Med* 11:25-30, 1982.
10. Fischl, M.A., Pitchenik, A., Gardner, L.A.: "An Index Predicting Relapse and Need for Hospitalization in Patients with Acute Bronchial Asthma," *NEJM* 305:783-9, 1981.
11. Rose, C.C., Murphy, J.G., Schwartz, J.S.: "Performance of an Index Predicting the Response of Patients with Acute Bronchial Asthma to Intensive Emergency Department Treatment," *NEJM* 310:573-6, 1984.
12. Becker, A.B., Nelson, N.A., Simons, E.R.: "Pulmonary Index," *AJDC* 138:574-6, 1984.

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In Five Consecutive Siblings

Sudden Infant Death

By Eugene F. Diamond, M.D./Maywood

Sudden Infant Death Syndrome (SIDS) is a leading cause of death in infancy. An attempt has been made to identify infants at risk[1,2] in the hope that prophylactic measures could be undertaken. In addition to premature infants, infants who have experienced a "near-miss" episode[3] and infants who have obstructive sleep apnea,[4] it is known that siblings of infants succumbing to SIDS are at slightly greater risk than the general population.[3,5] In some families, there is a striking incidence of recurrence of SIDS.[6] This case report involves a kinship in which five consecutive siblings died from SIDS and no child survived.

The patient was a 29-year-old gravida V, para V mother with the following family history. At age 18, she had had a premature infant girl born out of wedlock at 34 weeks gestation weighing 1,985 grams. The infant had multiple episodes of apnea in the nursery and required ventilator support in the perinatal period. The infant, discharged at one month of age, fed poorly and had multiple episodes of upper respiratory infection. At age five months, the infant was found apneic and cyanotic in her crib. She was taken to an emergency room by paramedics but attempts at resuscitation were unsuccessful. Autopsy by the medical examiner's office was consistent with Sudden Infant Death Syndrome.

Two years later, the mother married a man who was not the father of her first child. One year later, she delivered a female infant at term. There were no neonatal problems. The child had an uneventful course until age four months when the mother went to awaken the infant in the morning and found her dead in bed. Autopsy by the medical examiner was consistent with Sudden Infant Death Syndrome.

Eighteen months later, the mother delivered a female infant at term. Pregnancy and delivery were uneventful. At age one month, the baby had an episode of "choking on formula" and was seen at a hospital emergency room, where physical examination and chest x-ray were normal. Mother describes having tried a breath mouth-to-mouth resuscitation effort. At age six weeks, mother found the infant apneic and cyanotic in her crib. Paramedics arrived within 10 minutes, but attempts at resuscitation were unsuccessful. Autopsy by the medical examiner disclosed no apparent cause of death and the death certificate was signed out as Sudden Infant Death Syndrome.

The mother divorced the father of her second and third child one year later and married her present husband. Two years later she delivered a healthy male infant after an uncomplicated labor and delivery. The child is described as having been "healthy as a horse" with no episodes of significant infection. At age 13 months, the child was found dead in his crib after a mid-day nap. Autopsy was reported by the medical examiner as consistent with SIDS.

Two years later, the mother was referred to our institution in the seventh month of her fifth pregnancy. She was referred to an attending pediatrician and delivered a healthy male infant at term. Physical examination and hospital course in the nursery were entirely normal.

A sleep study was done at age 10 days which showed normal response to stress of hypoxia and hypercarboxia. The child was discharged on home monitoring. At age six weeks, a pneumogram was performed which was described as "remarkably normal" with a recording of eight hours of sleep time. Theophylline therapy was not recommended. The child was kept on continuous monitoring despite normal results. At age nine months, he began to have episodes of bradycardia three or four times a night. He was admitted and sleep studies showed normal response to CO_2 and hypoxia. A pneumogram done at another hos-

pital was abnormal (showing 11-19 second apneic episodes) and the child was started on theophylline 2.5 mg/Kg/day. The bradycardic episodes stopped and there were no further monitor alarms.

He was kept on theophylline for four months. Theophylline was discontinued at age 13 months. He was kept on home monitoring for an additional six months. There were no episodes of apnea or bradycardia while not on theophylline. Repeat pneumogram at age 18 months was normal. Monitor was discontinued at age 19 months.

The child was in good health for the next five months. At age two years, he developed a mild afebrile upper respiratory infection. Child was started on erythromycin because of a throat culture reported as showing B-Streptococcus in a contact. Mother and child took a nap together. Mother awoke and found the child sleeping peacefully. She left to greet visitors. She returned one hour later to find him apneic. All attempts at resuscitation failed. Autopsy by medical examiner was consistent with SIDS. The States' Attorney carried out a six month investigation of the case without finding evidence of foul play.

Summary

A kinship is reported in which five consecutive infants of one mother died of SIDS between the ages of six weeks and two years. The fifth child died despite repeated evaluations of sleep studies and pneumograms and despite theophylline therapy and 19 months of sleep monitoring at home. It is possible that this subgroup of repeated SIDS deaths in siblings may be etiologically distinct from the general population of SIDS deaths in infancy.

References

1. Carpenter, R.G., Gardner, A., Pursall, *et al.* "Identification of Some Infants at Immediate Risk of Dying Unexpectedly and Justifying Intensive Study, *Lancet* 2:343-346, 1979.
2. Beckwith, J.B., Bergman, A.B.: "The Sudden Death Syndrome in Infancy." *Hosp Pract* 22:44-52, 1967.
3. Ariagno, R.L., *et al.*: " 'Near Miss' for Sudden Infant Death Syndrome: A Clinical Problem," *Pediatrics* 7:726-730, 1983.
4. Frank, Y., Kraveth, R., *et al.*: "'Obstructive Sleep Apnea and Its Therapy," *Pediatrics* 71:737-741, 1983.
5. Valdes-Dapena, M.A.: "Sudden Infant Death Syndrome: A Review of the Medical Literature 1974-1979," *Pediatrics* 66:597-603, 1980.
6. Peterson, D.R., Chinn, U.M., Fisher, L.D.: "The Sudden Infant Death Syndrome: Repetitions in Familes," *J Pediat* 97:265, 1980.

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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Joseph Shanahan, M.D., Hinsdale, was recently called upon to serve as official medical adviser for the Hands Across America event on May 25. The sponsoring group and the American College of Emergency Physicians asked Dr. Shanahan to provide that service. . . . **Robert B. Klint, M.D.,** executive vice president, SwedishAmerican Hospital, Rockford, has been elected vice president by the American Academy of Medical Directors. Also at that meeting, **J. Roger Powell, M.D.,** Urbana, medical director for the Carle Clinic Association and vice president for medical affairs at the Carle Foundation Hospital, was named to their board of directors. . . . **Aziz U. Rahman, M.D.,** Centralia, and **Kamthorn Phaosawasdi, M.D.,** Bloomington, have been named fellows of the American College of Physicians.

FORMER ISMS CHAIRMAN HONORED

Morris T. Friedell, M.D., Chicago, former chairman of the ISMS Board of Trustees, will be honored at a dinner on August 6 at the Chicago Palmer House, when the Weizmann Institute of Science will establish the Dr. Morris T. Friedell Fund for Research Fellowships for Physicians. The dinner will feature remarks by Dr. Albert B. Sabin, who developed the oral polio vaccine and also served as the Weizmann Institute's fourth president. The fellowship, which is to be established in perpetuity, recognizes Dr. Friedell's professional and philanthropic contributions to medicine. Vincent A. Costanzo, Jr., Rph., M.D., of Jackson Park Hospital is dinner chairman.

SAFETY BELT CONFERENCE SCHEDULED

The sixth annual Occupant Protection Conference will be held September 12-13, 1986, at the Matteson Holiday Inn. More information about the conference, sponsored by the Illinois Child Passenger Safety Association and the Illinois Coalition for Safety Belt Use, may be obtained by contacting the Coalition at 944 S. Second St., Springfield IL 62704; 217-525-2891.

ISMS WINS GOLDEN TRUMPET AWARD

The Society was recently honored at the annual awards luncheon of the Publicity Club of Chicago. A prestigious Golden Trumpet Award, recognizing educational campaigns in the public sector, cited the ISMS Professional Liability Initiative, and also honored Market Opinion Research, Rick Simon & Co., and Burson-Marstellar. Market Opinion Research developed the research which structured the educational effort. Rick Simon & Co. developed the "Trivial Suit" slide presentation, and Burson Marstellar assisted in developing educational materials.

In citing the Society's intensive 1985 grassroots effort, which culminated in passage of the Medical Malpractice Reform Act of 1985, the award stated that literature and media coverage reached an estimated 65,950,000 citizens. These statistics were said to indicate that each of the 8.4 million adults in Illinois were exposed to an average of 7.9 media reports related to the malpractice initiative.

NEW SOCIETY FORMED

The American Association of Cardiovascular and Pulmonary Rehabilitation is a newly formed multidisciplinary organization dedicated to improving clinical practice, promoting scientific inquiry and advancing education on the subject. Membership information may be obtained by writing them at 53 Park Place, New York NY 10007; (1-212-766-4300).

EHLERS DANLOS SYNDROME

A national foundation has been formed to provide support for persons suffering from Ehlers Danlos Syndrome (EDS) and to educate medical professionals about EDS and related connective tissue disorders. Physicians interested in further information may contact Nancy Hanna, Executive Director, Ehlers Danlos National Foundation, P.O. Box 1212, Southgate, Michigan 48195.

(Continued from page 14)

Diagnosis: Broncholithiasis

Broncholithiasis is a benign disease which has been recognized as "coughing up stone" since antinquity. In 1950, Schmidt, *et al,* defined a broncholith as a calcification that has eroded partially or completely into a bronchus.[1] In 1971, a Mayo Clinic study proposed that penetration of a peribronchial calcification into the bronchial lumen is actually the terminal stage of a dynamic process.[2] They included distortion of the bronchial tree by the calcified mass leading to symptoms of partial or complete bronchial obstruction as a feature of the syndrome of broncholithiasis.[2] The cases presented demonstrate two manifestations of the syndrome.

Etiology

Broncholiths develop when respiratory motion causes the sharp edge of a calcified peribronchial mass to erode the adjacent bronchus. Any process which results in calcified hilar and peribronchial lymph nodes can lead to brocholithiasis. At one time tuberculosis was the major cause, but histoplasmosis is now recognized as the most common cause in the United States.[3] Other infections, such as coccidioidomycosis, cryptococcosis and actinomycosis are much less common. Rare causes include formation of a broncholith by calcification of an aspirated foreign body[1] and a calcified carcinoid tumor.[4]

Clinical

Broncholithiasis occurs with equal frequency in men and women. The time of presentation may be as early as the second decade of life, but the mean age of presentation is in the sixth decade. There are several clinical manifestations. All but the pathognomonic lithoptysis, which occurs in about one-third of patients, are nonspecific.[2] There is often a considerable delay—averaging about one year—from the onset of symptoms to diagnosis.

In a Mayo Clinic study of about 250 patients, the most frequent presenting symptom was cough caused by bronchial irritation or, rarely, bronchoesophageal fistula. Hemoptysis was also common. This varied in severity from blood-streaked sputum to massive hemoptysis due to erosion into the aorta or pulmonary artery. Less often, fever, chills and purulent sputum production occurred as a result of obstructive pneumonia.

Radiology

Radiologic examination is crucial in the diagnosis of broncholithiasis. Plain film findings[5] include hilar calcification (Fig. 3, 4) and a focus of calcification at the apex of segmental or lobar consolidation (Fig. 1-3), atelectasis (Fig. 4) or air trapping. In these patients the radiographic differential diagnosis includes endobronchial tumor and aspirated foreign body. Serial chest roentgenograms demonstrating a change in size or position of a calcified mass are also reported.

Conventional tomography (best when done in oblique or lateral plane)[5] and computed tomography are diagnostic when the broncholith is localized within the lumen. Chest CT combined with bronchoscopy is said to be nearly 100% effective in making the diagnosis.[6]

Bronchoscopy

Bronchoscopic findings[7] are: (1) widening of the carina, (2) stenotic bronchial lumen, (3) pigmentation or granulation tissue of the bronchial mucosa, and, most importantly, (4) actual visualization of the calcified mass within or protruding into the bronchial lumen.

Treatment

Often, the offending stone can be removed via the bronchoscope. Retrieval should be attempted only if the mass is freely moveable. The stone is frequently tethered by scar tissue to neighboring structures, such as the esophagus or major vessels.[8] Attempted removal in this case may result in a broncho-esophageal fistula or massive hemoptysis.

Surgery may be necessary if there are life-threatening or lifestyle-hampering symptoms, or if a malignancy appears possible. Specifically, recurrent or massive hemoptysis, a fistula between esophagus and airway, and severe or repeated post-obstructive pneumonia are recognized justifications for surgery.

As the disease is benign, the most conservative procedure should be chosen if surgery is required. Options[7] are debridement of nodes surrounding the bronchus, bronchotomy with stone removal and patching of the bronchial wall defect, and, most commonly, resection of the involved bronchus and the affected segment or lobe. Pneumonectomy is rarely required. Surgery is difficult. Significant morbidity and mortality are due to obliteration of normal tissue planes and anatomic landmarks by the chronic mediastinal and hilar inflammation.

Conservative therapy is used if the patient's symptoms are mild. The Mayo Clinic study of 210 cases with broncholithiasis illustrates the natural course of these patients. Sixty-eight surgically and 142 nonsurgically treated patients were followed for an average of 10 years. Sixty-five nonsurgically treated patients became asymptomatic spontaneously or with medical treatment. Seventy-seven patients remained symptomatic but 37 of these had only mild symptoms not requiring hospitalization. The 40 others required hospitalization due to recurrent obstruction or pneumonia. Seven had life-threatening hemoptysis. Eight patients eventually underwent surgery. Four patients died from complica-

tions of broncholithiasis.

Of the 68 surgically treated patients, two died in the immediate postoperative period. Two patients died after a prolonged complicated postoperative course. Fifty-seven were followed for an average of 10 years. Fifty remained completely asymptomatic, one developed recurrent broncholithiasis and two suffered from recurrent bronchoesophageal fistulas requiring further surgery. Four patients continued to have mild symptoms not requiring surgery.

References

1. Schmidt, H.W., Clagett, O.T., MacDonald, J.R.: "Broncholithiasis," *J Thorac Cardiovasc Surg* 19:226, 1950.
2. Arrigoni, M.G., Bematy, P.E., Donoghue, F.E.: "Broncholithiasis," *J Thorac Cardiovasc Surg* 62:231-7, 1971.
3. Baum, G.L., *et al.*; "Broncholithiasis Produced by Histoplasmosis," *Am Rev Resp Dis* 77:162-167, 1958.
4. Kirschner, P.A.: Letter. *J Thorac Cardiovasc Surg* 70:788, 1975.
5. Vix, V.A.: "Radiographic Manifestations of Broncholithiasis," *Radiol* 128:294-9, 1978.
6. Dixon, G.F., Donnerberg, R.L., Schonfeld, S.A., Whitcomb, M.E.: "Advances in the Diagnosis and Treatment of Broncholithiasis," *Am Rev Respir Dis* 129:1028-30, 1984.
7. Faber, L.P. *et al.*: "The Surgical Implication of Broncholithiasis," *J Thorac Cardiovasc Surg* 70:779-87, 1975.
8. Peabody, J.W.: Letter. *J Thorac Cardiovasc Surg* 70:788, 1975.

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Job Hunting Part Two

By Robin Bluestein, CMA-C

Part one of this article, published in the May IMJ, *addressed experience and preparation/planning for the potential medical assistant position. This article will focus on job interviewing and making the most of your job after being hired.*

You have sent a resume and/or answered a position advertisement. It's wise to follow-up with another letter or telephone call. This will express your continued interest in the position and enhance their interest in you.

When an interview has been scheduled, preparation is very important. Consider your responses to probable questions the interviewer might ask. Why are you applying for this position? What do you feel you can contribute to this position? What are your interests? How do you feel you work with other people?

Next, compile a number of questions that you might have for the interviewer. What will your responsibilities be? What are some of the job benefits? Is there room for advancement? Many more questions can be created and you should determine how you would answer them. Answering these questions will help prepare you for the interview.

Salary will be a major concern. What kind of salary can you expect? What salary do you feel you deserve with your experience and abilities? Determine the salary you would like to make and be able to negotiate to some extent. Unfortunately, it was my experience that offices were offering much less than I was willing to make. I found that employee turnover was very high in these offices. This told me that "they were getting what they paid for." It was my belief that if offices and physicians were willing to pay more for quality employees, job satisfaction would be high and physicians would benefit from their medical assistants' proficiency and contentment.

If possible, apply for several positions. Shop around for a position that fits your needs. Do not panic and think that this is the only position you will be offered (this happens occasionally with first-time job hunters). You may be surprised by the different positions you will be offered. Take your time to find the right spot.

The final concern is making the most of your job after being hired. Undoubtedly, you will be proficient in many office responsibilities, but some tasks must be learned. Offer to take a class to learn audiometry, show interest in a course on computerizing your office, or suggest that the entire office staff become certified in cardiopulmonary resuscitation (CPR). Your enthusiasm and interest will benefit your office and be an added plus for you (in your office and in general).

Some jobs are permanent. Some are just stepping stones to bigger and better things. Do not stay in a job where you do not grow or a job that you do not enjoy. If it is a comfortable position, but you are not growing, consider another option.

You can always go back to square one: check the Sunday advertisements, see what is available and take it from there. Good luck in your job search!

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 East Jackson Street Bloomington, Illinois 61701; Robin Bluestein, CMA-C, co-chairman, Public Relations Committee, 2247 West Estes Avenue Chicago, Illinois 60645; or Catherine M. Hill, CMA, co-chairman, Public Relations Committee, 900 South Plum Grove Road Palatine, Illinois 60067. ◀

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Flunarizine, prochlorperazine maleate, and placebo were evaluated for effect against motion sickness by means of the electronystagmic responses to motion. Flunarizine was shown to be a strong calcium antagonist that proved clinically useful in controlling chronic vertigo without the central depressive side-effect of antihistamines and anticholinergic drugs. It appears to be a good peripherally acting labyrinthine suppressant. (Lee, J., *et al: Av, Space, and Env Med* 57:1, 45-9, 1986)

Antibody-producing lymphocytes can be fused with cultured hybridomas that secrete specific monoclonal antibodies. These anti-cancer antibodies have been produced in treatment of cancers of the colon, breast, lung, and bone as well as melanomas. Radioisotope-labelled monoclonal antibodies have been tried in 15 cases of ovarian cancer by intraperitoneal administration with good amelioration. Similar approaches are being attempted for malignant peritoneal and pericardial effusions, intrahepatic arterial infusion for hepatic metastasis from colon cancer, and children with neuroblastomas. Cytotoxic agents may be targeted as antibody conjugates for additional therapeutic programs. (Baldwin, R., Byers, V.: *The Lancet* 8481:1, 603-6, 1986)

Synthetically-produced vaccines for diarrheal disease caused by enterotoxigenic strains of *E. Coli* were produced by the University of Rochester in New York and The Scripps Clinic in California and found to be effective in raising the antitoxin titers. The serums showed a fourfold increased titer, and the jejunal aspirate showed a sevenfold increased titer. This vaccine was administered orally to 13 volunteers. (Klipstein, F., *et al: The Lancet* 8479:1, 471-3, 1986)

In situ saphenous vein graft for infrapopliteal occlusive disease appears to be the treatment of choice in severe lower extremity arterial occlusive disease. Percutaneous balloon angioplasty, thrombolytic therapy and the hemorrheologic agent pentoxifylline have a definite but limited influence on the outcome. The rate of amputation without prior attempt at revascularization is decreasing. (Hallett, J., *Mayo Clin Proc* 61:5,369-76, 1986)

Microangiopathy remains the major cause of mortality and disability among patients with chronic insulin-dependent diabetes. Diabetic renal disease is the leading cause of death in these patients. Morphologic and functional studies of diabetic glomerulopathy are most accessible for investigation. The authors suggest that vasoactive substances, altered vasomotor responsiveness, chronic plasma volume expansion, and tissue hypoxia lead to microvascular vasodilation with consequent elevation of capillary pressures and flow. This injures the capillary walls, increasing the permeability of capillary walls to macromolecules with thickening of the wall and narrowing of the lumen. These changes reduce the functional reserves in various organs, *e.g.*, skeletal muscles, kidneys, retina, etc. (Zatz, R., Brenner, B.: *Am J Med* 80:3, 443-54, 1986)

Disorders of perception were studied in 205 unselected stroke patients by having patients cross out lines drawn on a sheet of paper. This Albert test showed abnormality in 49% of patients with non-dominant hemisphere lesions and 25% in patients with dominant hemisphere lesions. Abnormality was a significant predictor of both mortality and functional capacities six months after a stroke, independent of many other findings. The full series of tests for perceptual neglect was of no additional predictive value. (Fullerton K., *et al: The Lancet* 8478:1, 430-32, 1986)

Osteoarthritis is the result of cellular and joint tissue response of cartilage with fissuring and subsequent erosion. This response may be idiopathic or associated with aging. It may be found secondary to trauma, endocrine disturbance or inflammatory, metabolic, developmental and heritable disorders. The author suggests that metalloproteinases injure local chondrocytes or inflammatory mediators with consequent pathologic changes in the matrix of cartilage. (Howell, D.: *Am J Med* 80:4B, 24-8, 1986)

The death rate in California and Pennsylvania for a draft age population was compared among those who served in the military during the Vietnam War and those who did not. Only 26% of the men who were eligible for the draft actually entered the military. Military service during the Vietnam War increased the risk of death by suicide by 65% and for motor-vehicle accidental death by 49%. The group of men with birth dates that made them eligible for the draft had a higher mortality rate than the group with birth dates that exempted them from the draft. (Hearst, N., *et al: N Engl J Med* 314:10, 620-24, 1986)

A recent article recommends a screening examination for chlamydial infection in certain sexually active women. It specifies screening of those women aged 24 or less, who have had intercourse with a new partner within the past two months without the benefit of a barrier contraceptive method. This is recommended for those who have a purulent or mucopurulent discharge and exhibit bleeding of the endocervical mucosa on swabbing. This screening procedure is suggested as necessary and cost-effective. (Handsfield, H., *et al: JAMA* 255:13,1730-4, 1986) ◀

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

AUGUST

Internal Medicine

Specialty Review in Internal Medicine

For: Internists and medical subspecialists. Lecture, August 3-9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $730. **Reg. Limit:** None. **Credit:** Category 1: 62 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

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Neurosurgery Laser Workshop

For: Interested physicians. Workshop, August 18-19, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 12. **Credit:** Category 1: 19 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

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For: General and specializing surgeons. Lecture, August 18-19, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $840. **Reg. Limit:** None. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Fiberoptic Colonoscopy

For: Surgeons, internists, and gastroenterologists. Lecture, August 20-22, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1: 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Chemical Abuse

1986 Illinois Institute on Drugs and Alcohol

For: Interested medical personnel. Workshop, August 24-28, Pheasant Run, St. Charles, IL. **Sponsor:** Illinois Department of Alcoholism and Substance Abuse, 100 W. Randolph, Suite 5-600, Chicago, IL 60601. **Fee:** $90. **Reg. Limit:** None. **Credit:** None **Contact:** Emma Redmond. **Phone:** (312) 917-6432.

SEPTEMBER

Otolaryngology

Contemporary Head and Neck Reconstructive Surgery

For: Otolaryngologists. Workshop, September 24-27, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 60. **Credit:** Category 1: (hours to be determined). **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Otolaryngology Head and Neck Workshop

For: Otolaryngologists, DO's and DOV's. Laser workshop. September 29-30, Chicago, IL. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 25. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Nephrology/OB-Gyn/Family Medicine

Renal Function and Disease in Pregnancy

For: Nephrologists, obstetricians, and family practitioners. Symposium, September 18-20, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the National Kidney Foundation. **Fee:** $145. **Reg. Limit:** None. **Credit:** Category 1: 14 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Neonatology

Perinatal Care: Current Issues for the Primary Care Provider

For: Family practitioners, obstetricians and pediatricians. Seminar, September 11, Jumer's Castle Lodge, Urbana, IL. **Sponsors:** Carle Clinic Association, Educational Services, 611 W. Park Street, Urbana, IL 61801 and the University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $5. **Reg. Deadline:** 9/4/86. **Reg. Limit:** None. **Credit:** Category 1: 3.5 hours; AAFP Prescribed: 3.5 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3108.

Dermatology/Family Medicine/ Geriatrics

National Symposium on the Prevention and Treatment of Pressure Ulcers

For: Dermatologists, family practitioners, and geriatrics specialists. Symposium, September 23-25, Chicago, IL. **Sponsors:** The University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the Chicago Department of Health. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Internal Medicine/Family Practice

Office Treatment of Hypertension

For: Internists, family practitioners, cardiologists, and general practitioners. Conference, September 24, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 4 hours; AAFP Prescribed: 4 hours; and AOA: 4 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Psychiatry

Workshops for various specialties

For: Psychiatrists, anesthesiologists, family physicians, allergists, pediatricians. September 23-26, Chicago, IL. **Sponsors:** Society for Clinical and Experimental Hypnosis, 128-A Kings Park Drive, Liverpool, NY 13090; Department of Psychiatry and Department of Behavioral Sciences, University of Chicago; Department of Psychiatry, Michael Reese Hospital; Anesthesia Department, Northwestern University Medical School and Department of Psychology, University of Illinois at Chicago. **Fee:** $120-160 residents; $270-395 members; $340-480 non-members. **Credit:** Category 1: 30 hours; AAFP Elective: 30 hours; ADA: 30 hours; American Psychological Association: 30 hours. **Contact:** Marion Kenn. **Phone:** (315) 652-7299.

Critical Care/Medicine/Surgery

Fifth Annual Chicago Critical Care Symposium

For: Physicians and nurses. Lectures, tutorials, September 25-28, Chicago Marriott Hotel, Chicago, IL. **Sponsor:** University of Health Sciences/The Chicago Medical School, c/o Liz Brucchert, CME Office, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $360 for physicians, $220 for nurses. **Reg. Limit:** None. **Credit:** Category 1: 24 hours; AAFP Prescribed: 24 hours; AACN: 24 hours; and ACEP: 24 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Emergency Medicine

6th Annual Current Emergency Care Problems Conference

For: Physicians. Conference, September 11-12, Madison, WI. **Sponsor:** University of Wisconsin-Madison, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Emergency Medical Services Program, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; AOA Category 2-D: 11.5 hours; and Univ. of Wisconsin CEUs: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

October

Psychiatry

The Psychiatric Interview

For: Psychiatrists. Course, October 17-19, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Ob/Gyn/Geriatrics/Pediatrics/Urology

Medical Seminar-at-Sea (Mediterannean/Holy Land Cruise)

For: Physicians. October 19-November 1. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine

17th Family Medicine Review

For: Family physicians. Course, October 26-31. **Sponsor:** University of Kentucky College of Medicine, Office of CME, 132 COM Office Building, Lexington, KY 40536. **Fee:** $425 ($450 after 10/10). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP: 50 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Neurology

Clinical Neuroimmunology IV: Demyelinating Diseases and AIDS

For: Neurologists. Course, October 23-25. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Surgery

The Chicago Temporal Bone Surgical Dissection
For: Otolaryngologists. Course, October 6-10, Hinsdale Hospital, Hinsdale, IL. **Sponsor:** Dept. of Otolaryngology, Northwestern, Loyola University and Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521. **Fee:** $900-physicians; $600-residents. **Reg. Limit:** 8. **Credit:** Category 1: 40 hours. **Contact:** Cherie Jones, MPH. **Phone:** (312) 887-2400.

A Curative Approach to Sarcomas
For: Oncologists, pathologists, orthopaedic surgeons and radiation therapists. Course, October 17-18, Nordic Hills Resort, Itasca, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $75. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Elective: 7 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine/Internal Medicine

Comprehensive Care of the Diabetic Patient: An Update
For: Internists, family practitioners, and endocrinologists. Course, October 11, 9:00 a.m.-1:00 p.m., Highland, IN. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $30. **Reg. Limit:** None. **Credit:** Category 1: 3 hours; AAFP Elective: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Obstetrics/Gynecology

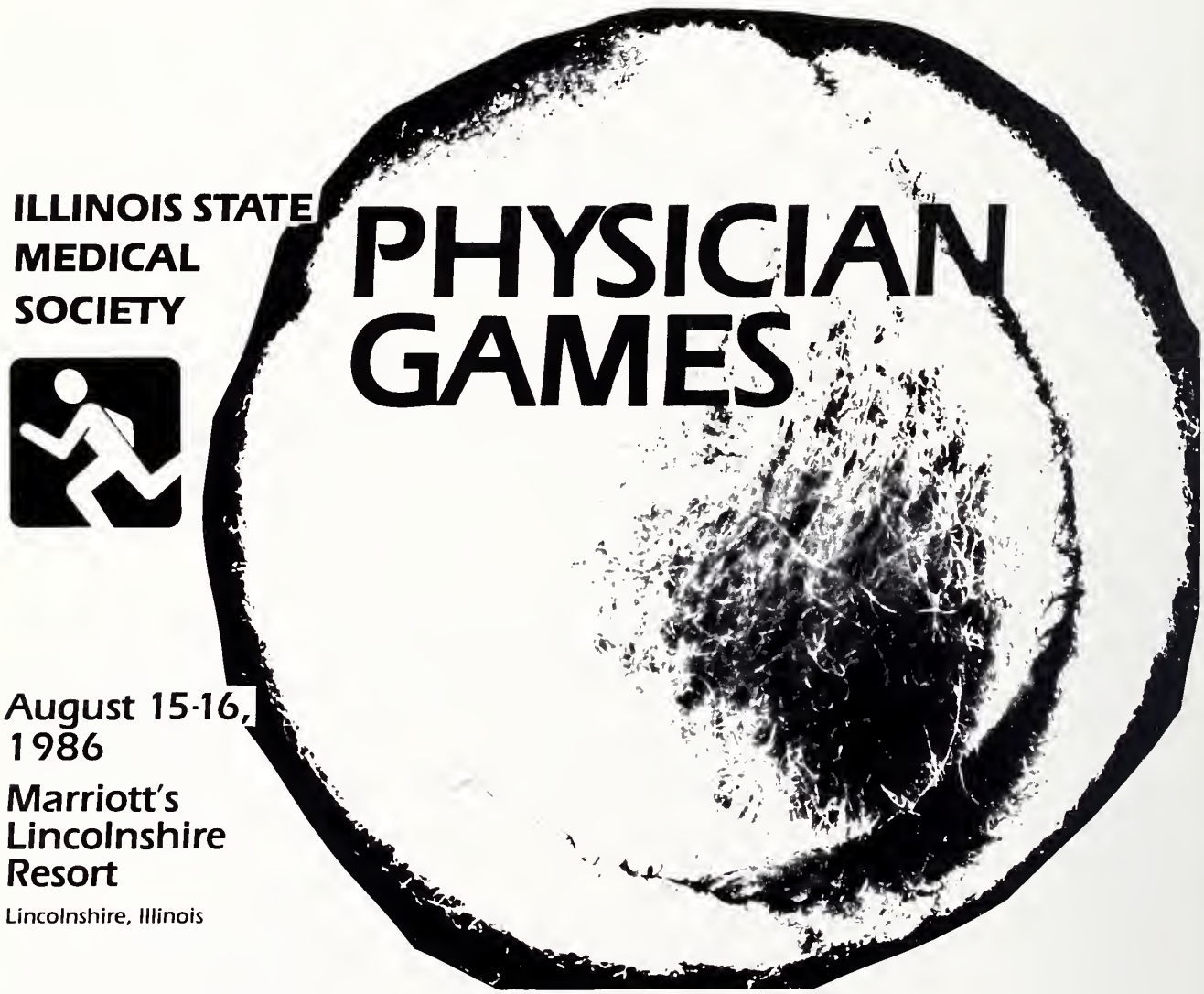
Perinatal Medicine-Back to the Basics
For: Perinatalogists, neonatalogists, and obstetricians. Symposium, October 16-17, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 13 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiology

Echocardiography 1986
For: Cardiologists and echocardiographers. Course and workshop, October 21-24, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $350. **Registration Limit:** 250. **Credit:** Category 1: 26 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolaryngologists. Laser Workshop, October 27-28, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Pentenney. **Phone:** (312) 908-8533.



FURTHER INFORMATION

For additional information regarding the ISMS Physician Games, contact ISMS at (312) 782-1654, ext. 1135.

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EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Allison Katz, Staffing Specialist. National Emergency Services, Inc., 255 Executive Drive, Suite 104, Plainview, NY 11803 or call (800) 645-4848.

ARIZONA BASED Physician recruitment firm has opportunities coast to coast. "Professionals working with Professionals." Over 14 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PRACTICE/Internal Medicine—Central Illinois. Various opportunities available: solo and group. Reply to Box 1186, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

CARDIOLOGY: 56-MD multispecialty group seeking second cardiologist to associate in an excellent growing consultative practice, combining both invasive and non-invasive opportunities. Well-equipped offices in a modern, accredited facility. Drawing area nearly 400,000 with two well-staffed, modern hospitals. Stimulating midwest, Big-10 university community of 100,000 with superb cultural advantages. Ideal for family. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship and subsequent income based exclusively on productivity. Send C.V. to Box #2004, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SOUTHERN CALIFORNIA. Well-established and successful HMO is seeking specialists and primary care physicians for our facilities in Los Angeles and Orange counties. Located in close proximity to major teaching centers, we offer the opportunity for continued professional development and rewarding clinical practice. Excellent compensation and benefits package, including profit sharing. Please send C.V. to: Director/Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500-24, Glendale, CA 91203.

WELL ESTABLISHED PRACTICE for sale. General practice and general surgery. Chicago suburb. Will introduce up to one year. Grossing over $200,000. Reply to Box #2006, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SURGEON: Looking for associate in the established practice of general surgery. Suburb of Chicago. Reply to Box #2007, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PRIMARY CARE PHYSICIAN for Northbrook clinic. Full or part time. An exciting opportunity to have your own practice with no overhead or start-up expenses. Send C.V. to Medical Director, 1186 Northbrook Court, Northbrook, IL 60062.

IMMEDIATELY NEEDED: Family practice/internist. Guaranteed $35/ hour plus percentage. Close to St. Louis. Hospital privileges: community and St. Louis. Call (618) 254-7478.

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INDUSTRIAL CLINIC needs physician part-time weekdays in southwest suburb. Need Illinois license and your own malpractice. Send resume and hours available to: Southwest Industrial Care, 7600 W 119th St, Palos Heights, IL 60463.

PLASTIC SURGEON needed part or full time for cosmetic surgery clinic. Equity participation available, excellent compensation. Beautiful facility in downtown location next to Michigan Avenue. Must be board certified and have excellent people skills. Our patients demand it! Please send C.V. in confidence to C S C, Attn: Executive Medical Director, 5855 N. Sheridan Rd., #9D, Chicago, IL 60660.

WANTED: ILLINOIS licensed physicians to perform life insurance histories and physicals. Also ECG. (312) 763-8744.

FAMILY PRACTITIONER: Midelfort Clinic, a 70-physician multispecialty group with a growing HMO, is seeking family practice physicians for several locations: main facilities in Eau Claire, Wisconsin, a university city of 50,000; a new satellite facility in Chippewa Falls, Wisconsin, a progressive community of 15,000; its satellite facility in Barron, Wisconsin, in a modern office adjacent to the hospital where call will be shared with seven other clinic family physicians. All offer excellent practice opportunities, attractive salary and fringes. Contact: Donald R. Griffith,

M.D., Medical Director, Midelfort Clinic, Ltd.; 733 W. Clairemont Avenue, PO Box 1510, Eau Claire, WI 54702-1510. (715) 839-5222.

FAMILY PRACTICE—Immediate need for two B/C family practitioners for opportunity in Phoenix, AZ. For more details, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

IMMEDIATE OPENING full-time emergency physician at trauma center southwest of Chicago. Considerable exposure to acute trauma. Partnership within one year, remuneration exceeding six figures. Must be board certified in internal medicine, or at least two/three years experience in emergency medicine. Contact W. L. Gordon, (815) 744-2800.

OB/GYN—Board eligible or certified. Full time position available September '86 with established St. Louis community health center. Contact V. Appoo Koenig (314) 241-2200.

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE OB/GYN, FP, pediatric physicians coast to coast. For further information, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PHYSICIAN AND PEDIATRICIAN—Michigan City, Indiana, 50 miles southeast of Chicago. Thirty-physician multispecialty group. Two fully accredited acute care hospitals with over 300 total beds. Modern, fully equipped clinic. Michigan City has a population of 60,000 with over 100,000 drawing area. Competitive salary, full benefits. Located on Lake Michigan. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

PHYSICIANS. Fully accredited 1200-bed county chronic disease and rehabilitation facility, affiliated with medical schools, has four positions available for Illinois licensed physicians: full time/part time—board certified in internal medicine with sub-specialty in pulmonary medicine; part time pathologist—board certified in both anatomical and clinical pathology; full time—board certified in family practice and full time—board eligible, family practice, must have completed three years residency training in family practice. Direct all inquiries with curriculum vitae to: Medical Administration, Oak Forest Hospital, 15900 S. Cicero Ave, Oak Forest, Illinois 60452. EOE.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice, pediatrics and OB-GYN. Positions include income guarantee and no capital investment. For more information, contact Barry Trautman, 8401 Hanley Industrial Ct., St. Louis, MO 63144, (314) 962-1233.

INTERNAL MEDICINE—Shelbyville, Indiana, 25 miles southeast of Indianapolis. Eight-physician multispecialty group seeking third internist. Modern fully equipped clinic, in-house lab. Ninety-bed hospital, 6-bed ICU. Competitive salary, full benefits. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

DIRECTOR AND EMERGENCY Physicians needed for 407-bed hospital located in central Illinois near the state capital. Annual volume is 29,000. Physicians will cover the emergency department, convenient care clinic, and industrial medicine clinic. Excellent compensation and professional liability insurance procured. Contact: Bob Shoemaker, Coastal Emergency Services, Inc., 6230 Busch Blvd., Ste. 300, Columbus, OH 43229; collect (614) 436-0418 west of the Mississippi R.; (800) 633-9964 east of the Mississippi R.; (800) 551-3859 in Ohio.

EXPERIENCED REPRODUCTIVE Endocrinologist is wanted for an IVF program. Board certification/eligibility, in OB/GYN, experience in infertility, fellowship in reproductive endocrinology, experience in reproductive sonography and surgery are mandatory. Laboratory skills in reproductive endocrinology/immunology are needed. Send C.V. to Norbert Gleicher, M.D., Chairman, Department of Obstetrics and Gynecology, Mount Sinai Hospital Medical Center, California Ave. at 15th St. Chicago, Illinois 60608.

PEDIATRICIAN/NEUROLOGIST—Alton, Illinois, 20 miles northeast of St. Louis. Nine-physician multispecialty group. Modern clinic fully equipped. Three hospitals, over 600 total beds, servicing a population over 100,000. Competitive salary, full benefits. Contact: Jean Malkasian, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

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HEALTHLINE PHYSICIAN SERVICES, An affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman at Healthline Physician Services, 8401 Hanley Industrial Ct., St. Louis, MO 63144.

PEDIATRICIAN/OTOLARYNGOLOGIST—Canton, Illinois, Nine-physician multispecialty group, 225-bed hospital/trauma center, 22 pediatric beds. Clinic includes lab, x-ray, out-patient surgery. Hospital staff of 45/strong referral base. Excellent salary. Complete benefits. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

BOARD CERTIFIED CARDIOLOGIST. 170-bed acute care hospital located in Chicago is seeking a board certified cardiologist to provide diagnostic services and manage the intensive care unit. Compensation is negotiable. Reply to Box #2012, c/o of *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

HEALTH CARE EXECUTIVE. A key government agency seeks a unique management professional to direct the activities of a multifaceted medical assistance program. This vital responsibility includes management (500 employees) of a comprehensive health care program designed to provide essential medical services to over one million needy recipients monthly. The individual sought must have the proper blend of specific health care purchasing experience plus demonstrated management skills. The necessary educational credibility is also mandatory. Salary negotiable. For complete details concerning this management opportunity, send resume to: Box #2013, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ORTHOPAEDIC SURGEON: Berwyn, Illinois. Needed—board certified/eligible orthopaedic surgeon to join active practice. Competitive first year guarantee leading to partnership available. Berwyn is a western suburb of Chicago. Reply to Box #2014, c/o *Illinois*

Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SITUATIONS WANTED

INTERNIST SEEKS part or full time position: days, evenings, or nights Chicago metropolitan area. Experienced in occupational/industrial and general practice. University trained. Reply to Box #1198, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

E.R. PHYSICIAN—Eight years experience. Board certified, BLS, ALS, ATLS trained. Looking for directorship or partnership. Reply to Box #2002, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

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NORTHWESTERN SUBURBAN General practice and real estate. Owner grossing $200,000+. Beautiful facility. Owner anxious to retire. Professional Practice Sales, 540 Frontage Rd., Northfield, IL. 60093 (312)441-6111.

THREE MONTHS rent free—medical office, super location in Oak Park, great parking. Two exam rooms, 1 office, 1 washroom plus reception area. $495.00. Call (312) 251-3746.

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OTOLARYNGOLOGY. Well established practice for sale. Located in the professional building of a 500-bed Chicago suburb hospital. Call (312) 475-2206.

SUBLET OFFICE SPACE for doctor. Fully equipped and furnished-Drs. private office-secretary area-5 exam rooms. Near Archer and Harlem (312) 586-0811.

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PRACTICE FOR SALE. Well-settled moderately busy, eight-year old pediatric practice located in northwest side of Chicago. Low rent and overhead. Terms negotiable. Call (312) 973-7362 evenings.

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PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

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Teamwork and the Medical Culture



We have recently heard heated debate in some areas of our state as to whether or not some decisions made by the ISMS leadership have benefitted the membership. Much of this, I think, can be blamed on a lack of communication, but it may be more a result of the way physicians most typically react.

A study funded by the Robert Wood Johnson Foundation pointed out some characteristics of physician behavior that sometimes lead to organizational problems. Data suggest that under conditions of stress or conflict, as when major disagreement occurs, physicians tend to withdraw support from the organization, assert authority, and fight stubbornly and emotionally for suboptimal points of view. They are likely to define success as winning, and failure as losing, rather than defining success as a mutually acceptable compromise. In short, they prefer when under stress to impose their point of view on colleagues.

There is a strong tendency to view the organization as a group support service which interferes with individual needs. This leads to stressing personal priorities over the good of the organization as a whole.

What style of leadership is needed in a group that is described as individualistic, controlling and combative?

Physicians place great importance on due process. Consequently, they look within the organization for leadership that assures appropriate due process.

Physicians believe in majority rule. We recognize that there is a point where individuals expressing opposing views must conclude their points and formulate a decision.

Finally, physicians are concerned about high morale within their professional organization. In short, we are aware of the complex, competitive, individualistic environment, and seek to ensure morale through due process and majority rule, realizing that teamwork, in the sense of high affiliation, is not typically part of the medical culture.

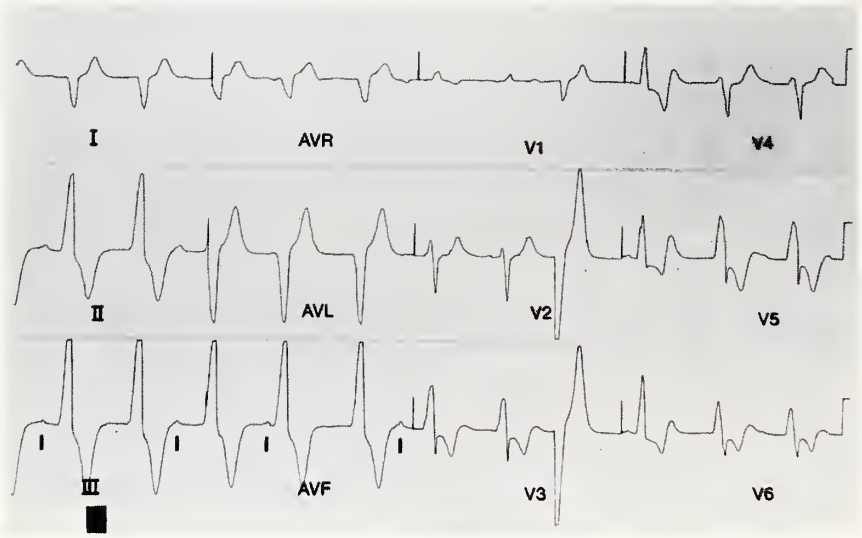
ISMS, as an organization, embodies these premises. Some of our members should be leaders but choose not to lead, while others, who might have interest in high leadership positions, could never be effective. At the state and county level, we have effective leaders who sometimes have to make very difficult decisions after wading through emotionalism and rhetoric. Concepts should be brought before the membership for input and debate, but it is the leadership's responsibility to make the final line- by-line decision.

If we were to involve large groups in every decision, very little could ever be accomplished. However, when members are allowed and encouraged to give input before decisions are made, acceptance and high morale should result. ◀

Jere E. Freidheim, M.D.
President

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a thirty-three year old man who was known to have congenital aortic stenosis. He suffered subacute bacterial endocarditis at age 16 and one year later he needed an aortic valve replacement with a ball-in-cage prosthetic valve. Eight years ago there was prosthetic valve malfunction and a second surgery was performed. The ball-in-cage valve was replaced by a porcine prosthetic valve in the aortic position. Postoperatively, complete right bundle branch block developed. The patient became asymptomatic and did well until two weeks prior to admission, when he developed dyspnea on exertion, especially climbing stairs. There was also a complaint of vague chest discomfort but it was not associated with exertion. He denied syncope or near syncope.

His physical exam showed a blood pressure of 136/96mmHg and a pulse rate of 70 beats per minute. He had normal lungs and no jugular venous distension. Examination of the heart showed a normal first heart sound and a split second sound without a ventricular gallop. There was a grade ⅓ systolic crescendo/decrescendo murmur which was heard all over the precordium, but was loudest at the base of the heart. Cardiomegaly was suggested by a point of maximal impulse in the sixth intercostal space, anterior axillary line. The admission blood tests were normal. This twelve lead ECG was obtained.

Questions:

1. **The twelve lead ECG shows:**
   a. New onset complete left bundle branch block.
   b. A recent myocardial infarction.
   c. Near complete atrioventricular (AV) dissociation with an accelerated idioventricular rhythm.
   d. Ventricular tachycardia.
   e. Severe right ventricular hypertrophy.

2. **Treatment for this patient could include:**
   a. Another cardiac catheterization.
   b. A permanent demand pacemaker.
   c. Intravenous lidocaine.
   d. Open heart surgery.
   e. All of the above.

(Continued on page 106)



Effective, not overpowering

Anxiolytic therapy affects more than just the patient...think of the people who rely on your patient every day. TRANXENE® provides effective relief of anxiety symptoms, but without overpowering your patient's ability to function normally. Studies comparing Tranxene and placebo have shown no reduction in fine motor skills[1*] as well as no significant memory deficit in normal subjects after acute administration.[2,3]

*As with all benzodiazepines, patients should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery, including motor vehicles.

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TRANXENE®
(clorazepate dipotassium) ℞

TRANXENE®
(clorazepate dipotassium) ©

Brief Summary of Prescribing Information

INDICATIONS – For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS – Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS – Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS – Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS – Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS – Potentiation may occur with ethyl alcohol, hypnotics, barbituates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE – Take general measures as for any CNS depressant.

SUPPLIED – TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCES:

1. Scharf MB, Khosla N, Brocker N, et al: Differential amnestic properties of short- and long-acting benzodiazepines. *J Clin Psychiatry* 45:51-53, 1984.

2. Healey M, Pickens R, Meisch R, et al: Effects of clorazepate, diazepam, lorazepam, and placebo on human memory. *J Clin Psychiatry* 44:436-439, 1983.

3. Scharf MB, Hirschowitz J, Woods M, et al: Lack of amnestic effects of clorazepate on geriatric recall. *J Clin Psychiatry* 46:518-520, 1985. 6073791

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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State Supreme Court Upholds Four of Five Malpractice Reforms

On June 20, the Illinois Supreme Court issued its final ruling on legal challenges to the constitutionality of the Medical Malpractice Reform Act of 1985. Reprinted below are excerpts from ISMS President Jere E. Freidheim's comments to the press.

Next month, IMJ *will provide a substantive review of the decision and what must yet be done to restore total equity to the Illinois malpractice climate.*

Most of our readers know the story. On June 25, 1985, Illinois Governor James R. Thompson signed into law the Medical Malpractice Reform Act of 1985, a bill which represented the culmination of a major grassroots effort by physicians and patients across Illinois. One hour later, a Chicago plaintiff attorney filed suit challenging the constitutionality of the law and barring its implementation. In December, Cook County Circuit Court Judge Joseph Wosik found in favor of the plaintiff, declaring five key provisions of the new law to be unconstitutional. The attorney general appealed that ruling to the Illinois Supreme Court. On June 20, 1986, nearly a year after it was first signed, the Court reversed the ruling, and upheld the constitutionality of four of the five key elements.

"Illinois patients today won a great victory in the state Supreme Court's decision to uphold the very heart of medical malpractice reforms passed by the General Assembly last year," ISMS President Jere E. Freidheim said in a statement to the press following the Supreme Court decision. "In reaffirming four of five key challenged elements of the new law, the court has recognized the current imbalance in Illinois' civil justice climate and acted to begin restoring equilibrium."

The Court upheld structured verdicts, abolition of punitive damages, collateral source reductions and contingent fee limits for medical malpractice cases. Pre-trial screening panels were struck.

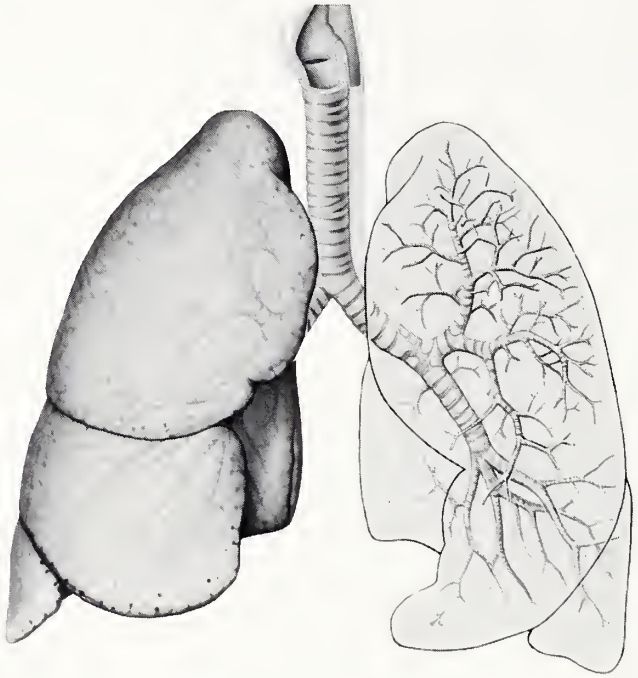
"While disappointed with the Court's action to strike down pretrial screening panels, we are appreciative and proud that Illinois' top court has taken positive action to solve the current crisis, rather than protecting the legal system's status quo," Dr. Freidheim said. "We are certain that these reforms will have a long term positive impact on the quality and cost of patient care in Illinois. Truly injured patients will get speedy justice and fair compensation under the new system."

Dr. Freidheim pledged that the Society would fully participate in efforts to implement the new law, and emphasized that additional reforms were needed. "Restoring balance to Illinois' civil court system means a long-term commitment," he said. "Illinois physicians will next year present two more essential tort reforms for state legislative deliberation: caps on non-economic awards and a more reasonable statute of limitations for minors injured through medical negligence."

Dr. Freidheim congratulated and thanked the legislature, governor and members of the state Supreme Court for their efforts in reforming the medical malpractice legal climate. "Due to your actions," he said, "all patients will benefit for a long time to come."

IMJ will feature an in-depth treatment of the Supreme Court decision next month. ◀

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae*, *H influenzae*, *Streptococcus pneumoniae*, *Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note. Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

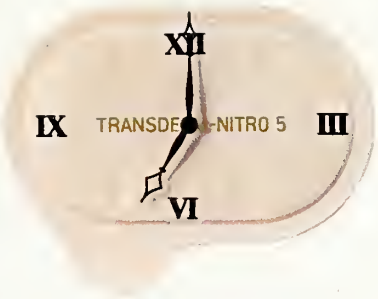
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Puts in a full day's work

Transderm-Nitro®

nitroglycerin

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information on the following page.)

C I B A

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Transderm-Nitro®
(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INOICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINOICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

OOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26) *100 Systems (NDC 0083-2025-30)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

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C I B A

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:

Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

CARBONDALE:

Multi-specialty group needs the following physicians: Otolaryngologist, Ophthalmologist, Neurologist and OB/GYN physician. Contact Wayne Given, 2601 West Main, Carbondale 62901. (6)

FAIRFIELD:

Family oriented Southern Illinois community with 50 bed, full service hospital recently undergoing extensive renovation seeks board certified and residency trained family practitioner to join an established young practitioner as an associate in a busy practice. Must be qualified in, and enjoy obstetrics, as this is a major portion of the practice. A fully equipped clinic with x-ray and lab facilities is available. The service area of this community is 25,000 and there are presently only 5 full time physicians in the area. Guaranteed salary with incentive. This is an excellent opportunity for a physician who wishes to establish a practice quickly and to be financially comfortable in a small community which is an excellent place for raising children. Send CV to Michael A. Blood, M.D., Fairfield Memorial Hospital, Fairfield 62837, or call 618-673-2135. (6)

GRAYVILLE:

On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:

Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

History and a Historian

In keeping with our policy of striving to preserve the historical traditions of our state and our profession, this month's issue of the *Journal* includes a scholarly look into the life of Dr. Charles Ellet Lippincott, a country doctor with adventuresome spirit. This delightful piece was authored by Emmet F. Pearson, M.D. who is Clinical Professor Emeritus of Medical History in the Department of Medical Humanities at Southern Illinois University School of Medicine, Springfield.

We recently had the happy occasion of celebrating Dr. Pearson's eightieth birthday at a reception in the Pearson Museum of Southern Illinois University School of Medicine. Through Dr. Pearson's generosity, a large part of the memorabilia of medical history from central and southern Illinois has been preserved in a museum located in the school of medicine. An organization entitled "Friends of the Pearson Museum" was announced at the time of this celebration. This is a charitable organization, part of the SIU Foundation, with the purpose of obtaining funds for the support of the museum.

It is indeed gratifying to have been acquainted with a rare individual who not only gives of his resources to develop and maintain an outstanding museum of medical history, but also gives of himself in the preparation of many manuscripts devoted to medical history, the latest of which we have the privilege of publishing in the *Illinois Medical Journal.*

J. William Roddick, Jr., M.D.
Chairman
IMJ Editorial Board



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning. May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminaphen or hydracadane.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydracadone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydracadone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

KNOLL PHARMACEUTICAL COMPANY
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A New Partnership

Medical Staffs and Political Action

The summer of 1986 may best be remembered as the dawning of HMSS political awareness. Three unprecedented hospital medical staff IMPAC contributions made the month of June one for the record books in the annals of medical politics.

Officials of the ISMS Hospital Medical Staff Section (HMSS) and the Illinois State Medical Society Political Action Committee (IMPAC) were pleasantly surprised at the June 14 caucus of the HMSS when the South Suburban Hospital medical staff made an unprecedented $15,000 contribution to IMPAC.

The medical staff of South Suburban Hospital in Hazel Crest was the first to so dramatically demonstrate their commitment to the concept of medical involvement in the political process.

A few days later, IMPAC received another $15,000 contribution from the medical staff at Ingalls Memorial Hospital in Harvey.

Clearly, the medical staffs were beginning to sense their potential as powerful political forces in Illinois. Two record-setting contributions in a week's time were remarkable. A third $15,000 contribution a few days later was astonishing. The medical staff at St. James Hospital in Chicago Heights was responsible for the third donation.

IMPAC Chairman George T. Wilkins, Jr., M.D., said that the contributions were noteworthy in several respects. Not only were they unprecedented amounts, but they represented landmark efforts by hospital medical staffs to work together for political action.

"These very generous contributions represent the beginning of what I hope will become an IMPAC tradition of hospital medical staff



Allan L. Goslin, M.D. (left), ISMS president-elect, accepts a $15,000 donation to IMPAC from the South Suburban Hospital Medical Staff during the June 14 caucus of the ISMS HMSS. Joseph T. Branit, M.D. (right), HMSS Representative for South Suburban, presents the contribution.



William H. Shackelford, M.D. (podium) served as Reference Committee Chairman for the 1986 Annual Meeting of the AMA HMSS in Chicago, June 12-15. Dr. Shackelford is HMSS Representative for St. Mary's Hospital Medical Staff, Decatur.

participation in the legislative process," he said. "Not all hospitals are in a position to make large contributions," he added, "but we do stress the importance of participation. IMPAC's strength is built on the foundation of individual contributions. The advent of hospital medical staff PAC contributions offers medicine an opportunity to expand involvement in the electoral process."

Dr. Wilkins pointed out that the remaining legislative battle for malpractice reform would make 1986 a critical election year for organized medicine in Illinois. Funds are sorely needed, he said, to ensure that good candidates have a fair opportunity to get elected. "Whoever wins the battle next year over award caps probably will be determined on election day, November 4, 1986," he said. "IMPAC could, as it has in the past, make the difference in campaigns where the candidates hold opposing views on malpractice legislation."

Robert C. Hamilton, M.D., chairman of the ISMS Governmental Affairs Council, explained that next year ISMS will be seeking legislation capping the amount of non-economic damages that can be awarded in malpractice suits. "We will need legislators in the General Assembly who understand how important this legislation is to the future cost and availability of health care in Illinois," he said.

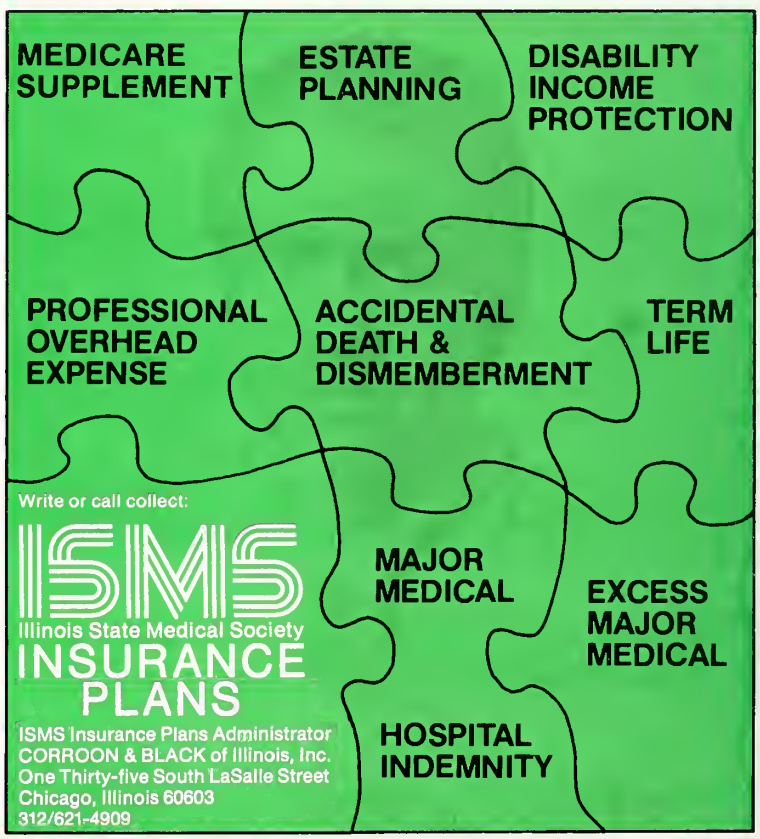
Further information about IMPAC may be obtained by contacting the Society at (312) 782-1654.

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No Way To Run a Railroad

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

The Apollo Cafe is usually what might be referred to as an integrated restaurant. No, that may be too extreme a statement. Restaurant brings up a mental image of greater class than the Apollo can boast. But the clientele/customers, are integrated—meaning that all are gratefully welcomed—and as long as there is an open chair at the 10 o'clock round table, "pull up and set!"

Well, sir, that's the attitude that prevails until mid or late summer, when we begin to integrate out some of our farm friends. Nothing wrong with farmers, and we're all fond of those pure row crop farmers, but we don't have many of those. Most around Mt. Hawley, like Willard and Rapheal, also have stock, and frequently head for the Apollo right after the morning chores, which gets them to us as the 10 o'clock round table is convening. Bad enough at any time, but in August!! Whew!! Swear the stuff they walk in soaks right through the gum boots!!

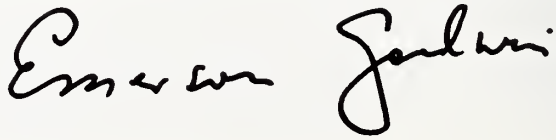
Yesterday, here they came, Raphe and Willard and their hired hand, all stamping their feet on the sidewalk, as though they could get rid of it, and into the Apollo. Hoots, gagging, nose holding, and pointing customers guided them to the booth in the back—on the opposite side from the kitchen. Everyone breathed cautiously, in a shallow way, and then settled back into a more conversational mode. Chic, however, wasn't going to leave it there.

Being in the insurance business, Chic fancied that he knew a little about law. With that authority in mind he called to the back booth. "You stinkers had better not be setting your hog prices, or deciding who will get how many pigs per sow, or you will be in trouble with the FTC."

"What's that all about?" asked Lefty, as she set down a mug of coffee. Responding to the audience, Chic elaborated, "It's against the law—FTC, antitrust—all them things, for people of the same occupation to get together and talk about the business side of their business. Suppose it's alright for the farmers to talk about the weather, or the realtors to talk about what a great place Mt. Hawley is, but if the talk is about business or money—they could get in trouble with the law."

"If this is the way it is," murmured Asa, "we're going to have to divide up the tables with one farmer, one mailman, one barber—one of each type at each table. Then no two of a kind will talk with each other—or worse, I could end up at the table with Willard."

That whole exchange brought a few laughs, but was also very much like what I read about the fears of you doctors. As I understand it, you have given up real peer review—if fees or anything like that is included. You dare not talk together about common financial interests. Other groups, the state, the federal government, insurance carriers, almost anyone else can figure out what they will do with, for, or to you, but you can't get together for those discussions among yourselves. Sounds crazy to me. No way to run a railroad—or an army. Think what that would mean if the officers couldn't get together and discuss strategy—costs, possible gains... Something just isn't right here. Wish I could figure it out... ◀



Yours,
E. Goodwin

OBITUARIES

***Cernock, William F.,** Western Springs, died June 24, 1986 at the age of 66. Dr. Cernock was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Cummins, George M., Jr.,** Chicago, died June 20, 1986 at the age of 72. Dr. Cummins was a 1941 graduate of Rush Medical College, Chicago.

****Daro, August F.,** Wilmette, died June 24, 1986 at the age of 86. Dr. Daro was a 1926 graduate of the University of Health Sciences/Chicago Medical School.

***Goldberg, Lowell,** Olympia Fields, died June 14, 1986 at the age of 61. Dr. Goldberg was a 1952 graduate of the University of Illinois College of Medicine, Chicago.

****Hawkins, Robert J.,** Tucson, Arizona (formerly of Chicago), died June 30, 1986 at the age of 81. Dr. Hawkins was a 1930 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Huber, Robert B.,** Elgin, died June 5, 1986 at the age of 59. Dr. Huber was a 1953 graduate of Northwestern University Medical School, Chicago.

***Jayne, Harold A.,** Chicago, died June 20, 1986 at the age of 43. Dr. Jayne was a 1969 graduate of the Wayne State University School of Medicine, Detroit, Michigan.

***Jorel, Louis E.,** Salem, died May 26, 1986 at the age of 62. Dr. Jorel was a 1953 graduate of the University of Virginia School of Medicine, Charlottesville, Virginia.

***Kaplan, Louis G.,** Chicago, died June 11, 1986 at the age of 74. Dr. Kaplan was a 1937 graduate of Rush Medical College, Chicago.

Martinez, Noly, Chicago, died June 19, 1986 at the age of 63. Dr. Martinez was a 1946 graduate of the Facultad de Medicina de la Universidad de la Habana, La Habana, Cuba.

****Mustell, Robert R.,** Chicago, died June 22, 1986 at the age of 92. Dr. Mustell was a 1919 graduate of the University of Illinois College of Medicine, Chicago.

***Oester, Yvo T.,** New Smyrna Beach, Florida, died June 19, 1986 at the age of 77. Dr. Oester was a 1943 graduate of the University of Chicago Pritzker School of Medicine.

****Oldberg, Eric,** Lake Forest, died June 28, 1986 at the age of 84. Dr. Oldberg was a 1928 graduate of Northwestern University Medical School, Chicago.

****Roth, Leslie W.,** Punta Gorda, Florida, died December 19, 1985 at the age of 79. Dr. Roth was a 1930 graduate of the Washington University School of Medicine, St. Louis, Missouri.

***Ryan, James H.,** Kankakee, died June 25, 1986 at the age of 58. Dr. Ryan was a 1952 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

****Shropshear, George,** Chicago, died June 11, 1986 at the age of 80. Dr. Shropshear was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

***Sipos, Stephen H.,** Waukegan, died July 3, 1986 at the age of 71. Dr. Sipos was a 1949 graduate of Orvosi Fakultas Tudomanyegyetem, Budapest, Hungary.

****Sippy, H. Ivan,** Rio Rancho, New Mexico (formerly of Chicago), died June 17, 1986 at the age of 84. Dr. Sippy was a 1930 graduate of Rush Medical College, Chicago.

****Wilkinson, Scott J.,** Decatur, died June 8, 1986 at the age of 87. Dr. Wilkinson was a 1924 graduate of the Johns Hopkins University School of Medicine, Baltimore, Maryland.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

ABSTRACTS OF ACTIONS

June 21-22, 1986

ISMS Conference Complex

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

HOLD HARMLESS

Recently, a physician treated a patient who was a minor-dependent of an employee-beneficiary of an employer's self-insurance. The employer advised its employee that if the beneficiary chose not to pay the difference between the insurance reimbursement and the physician's charge, court costs and any judgment which might result against the patient would be paid. In this instance, the physician had a signed statement from the minor that the patient would pay the physician's fee regardless of the amount paid by a third party. These types of cases have come to the attention of the Council on Economics and the Board of Trustees. However, this case was the first reviewed in which the physician had a written agreement concerning the fee with the patient. This case is complicated by the unpredictability of court costs and the minor status of the patient who signed the agreement.

The physician's attorney suggested that an appropriate activity for the Society would be publicizing language for a physician/patient agreement which contains the ability for the physician and patient to fill in a specific fee amount.

The Board evidenced concern that this could be a legal quagmire leading to unintended results. Publicizing appropriate agreement language is a more prudent course than legal action.

The Board authorized development of physician/patient agreements which would provide for designation of a specific fee to be paid by the patient for the particular service rendered by the physician. This document is to be an informational document, which the individual physician is free to use on a purely voluntary basis. The amount of the fee is solely to be determined by agreement between the individual physician and the patient.

STATE EMPLOYEES HEALTH PROGRAM

The State of Illinois is in the process of becoming self-insured for health insurance. The State has decided upon the Equitable Group and Health Insurance Company to act as the administrator of its program. A PPO network of hospitals for employees and dependents is being formed. Employees who utilize PPO hospitals will pay lower copayments and deductibles than employees who utilize non-PPO hospitals. In any case, no employee, whether utilizing PPO or non-PPO hospitals, will pay more than $1,000 per year out-of-pocket (combined physician and hospital expenses).

In the process of engaging Equitable as its administrator, the State will be relying on Equitable to administer its utilization review program. The Board agreed to recommend that the State consider utilizing the Crescent Counties Foundation for Medical Care (Downstate) and Illinois Foundation for Medical Review (Cook County) to hear any appeals which might arise from Equitable's determinations. ISMS will monitor this program and make further recommendations if warranted.

DIRECTORS AND OFFICERS LIABILITY INSURANCE

The Board reviewed a report from legal counsel regarding a request from the underwriters for the Society's Directors and Officers Liability Insurance to add an indemnification clause to the bylaws. The Directors and Officers Liability Insurance would stand in place of the corporation in the event there was an obligation to reimburse the trustees, officers and/or employees. Without the indemnification clause, the insurance could not stand in place of the entity. Bylaws can be amended only by the House of Delegates.

The Board adopted the resolution prepared for the Board of Trustees for indemnification by the Society for trustees, officers and employees; and approved a resolution for submission at the next House of Delegates amending the bylaws by the addition of Chapter XVI, Indemnification.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Vasotec Tablets (enalapril maleate), Betagan Ophthalmic Solution (levobunolol hcl), MS IR Tablets (morphine sulfate), Intal Aerosol Inhaler (cromolyn sodium), Citrucel Fiber Powder (methyl-cellulose), Mexitil Capsules (mexiletine hcl) and Colyte Powder.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Protropin (somatrem), Modrastane (trilostane), Dermagran Organic Spray, Pilopine H.S. Gel (pilocarpine HCL), Algicon (aluminum hydroxide/magnesium carbonate [magnesium alginate]), Diprolene (betamethasone dipropionate), Nitrolingual (nitroclycerin), Haldol Decanoate (haloperidol decanoate), Temovate (clo-

betasol propionate) and Tavist (clemastine fumarate).

The Board reaffirmed its previous recommendation to not include Calderol 20 mcg and 50 mcg capsules in the IDPA Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Accepted the February 28, 1986, Financial Statements; June 2, 1986, IMPAC Collection Data; May 31, 1986, Dues Payment Report; and Requests for Changes in Membership Status.
- Approved establishment of a Committee on CME Activities under the Council on Education and Manpower. The committee is needed to guide ISMS in its education activities and to apply for and maintain accreditation of ISMS as a CME sponsor.
- Discontinued the Committee on Committees.
- Suggested the Council on Education and Manpower meet with the Council of Deans to generate ISMS membership among academicians and to encourage student membership through the Deans' offices.
- Suggested that the Council on Public Relations and Membership Services consider development of a Young Physicians Section.
- Agreed that the Chairman of the Board of Directors of the Illinois State Medical Insurance Services should serve as an ex-officio member of the ISMS Board of Trustees and Executive Committee, and that the necessary bylaw amendment be developed for presentation through a resolution to the next House of Delegates.
- Approved sponsorship of the following INTRAV trips for 1987; South Pacific, Grenadines/Orinoco River, Bali/Far East, Trans-Panama Canal, Canadian Rockies, Scandinavian Fjords, Queen Elizabeth II and London, China, India and Nepal, Canyonlands of America.
- Directed that the results of a survey of hospital medical staffs (to determine activities being undertaken in various institutions pertaining to mandated levels of professional liability insurance as a condition of staff privileges) be sent in a narrative form with a cover letter stating ISMS' position to presidents of hospital medical staffs.
- Ratified a letter of endorsement of the Crescent Counties Foundation for Medical Care to continue as the Peer Review Organization for Illinois.
- Accepted the resignation of Dr. Clifton L. Reeder from his position as ISMIS Director; and ratified the selection of Dr. Ulrich F. Danckers to fill this unexpired position.
- Endorsed the Southern Illinois University School of Medicine Doctors Fair scheduled for September 12, in Springfield.
- Approved the legislative positions delineated in a primary list of House and Senate bills of interest to ISMS.
- Approved criteria for ISMS Public Service Awards. These awards will honor physicians and non-physicians for outstanding public service and community outreach efforts on health care issues.
- Agreed to give special consideration in appointing Board consultants for the Committee on CME Accreditation and the Council on Education and Manpower to the CME Accreditation Appeals Panel, in order to comply with recommendations of the Accreditation Council for Continuing Medical Education (ACCME) Surveyors.

MEETINGS

The Board:

- Agreed to hold the: (1) 1987 Interim/All Member Conference Meeting at the Ramada Inn, Mt. Vernon (date and meeting arrangements are pending); (2) 1988 Interim/All Member Conference Meeting at the Renaissance Hotel in Springfield; and (3) 1988 Annual Meeting on April 22-24, at the Westin O'Hare Hotel.
- Agreed to hold an All-Member Conference at the Drake Hotel, Oak Brook, November 8-9, 1986, in lieu of an Interim Session, with emphasis on Professional Liability Initiatives, Sunsetting of the Medical Practice Act, Physician Contracting and other matters that might be appropriate.
- Approved the following meeting schedule for the next administrative year:

Jun. 21-22, 1986	Jan. 17-18, 1987
Sep. 20-21, 1986	Apr. 09-12, 1987
Nov. 07-09, 1986	Jun. 13-14, 1987

NOMINATIONS & APPOINTMENTS

Acting on recommendations of the Councils and Executive Committee, the Board:

- Ratified appointment of: (1) Dr. Robert M. Vanecko to fill the unexpired term of Dr. David S. Fox, as delegate to the AMA; and (2) Ms. Edie Zusman, to replace Jennifer Souders, alternate delegate to the AMA, as nominated by the ISMS Medical Student Section.
- Ratified appointment of ISMS members to one-year terms on the Society's councils and committees for 1986-87.
- Appointed council chairmen: Drs. Fred Z. White, Chillicothe, Council on Economics; Boyd McCracken, Sr., Greenville, Council on Education and Manpower; Robert C. Hamilton, Chicago, Governmental Affairs Council; Geoffrey Bland, Springfield, Medical Legal Council; Joseph D. Winterhalter, Jacksonville, Council on Medical Services; Silvana Menendez, Belleville, Council on Mental Health and Addiction; and Jane Jackman, Springfield, Council on Public Relations and Membership Services.
- Appointed chairmen of committees reporting directly to the Board: Drs. Donald F. Pochyly, Hines, Committee on CME Accreditation; Vincent A. Costanzo, Jr., Chicago, Committee on Drugs and Therapeutics; Robert M. Vanecko, Chicago, Committee on Health Planning; L. Michael Newman, Evanston, Committee for the Impaired Physician; Boone Brackett, Oak Park, Peer Review Appeals Committee.
- Ratified the appointment of Drs. Alfred J. Kiessel, chairman, Alfred J. Clementi, Jere E. Freidheim, Allan L. Goslin, Robert C. Hamilton, Harold L. Jensen, Warren D. Tuttle and Fred Z. White, to an Advisory Committee on Professional Liability In-

surance. The committee will monitor tort reform in the General Assembly and plan for Initiative II.

- Nominated Dr. Riad Barmada, Professor of Orthopaedics, University of Illinois College of Medicine, Chicago, to serve on the Medical Practice Examining Committee of the Department of Registration and Education.
- Ratified the credentialing of Edie Zusman to replace Nancy Zamora at the June AMA Meeting.
- Referred appointment of an AMA Resident Delegate to replace Dr. Michael L. Nieder to the Executive Committee.
- Nominated the following physicians to serve on the newly created IDPH Board of Public Health Advisors: Drs. Donald Graham, Springfield; Henrietta Herbolsheimer, Chicago; Donald Van Fossan, Springfield; and Richard Zelazny, Melrose Park. The Board will meet on emergency medical concerns related to public health in times of crisis.

OTHER MATTERS

It was reported that the Health Policy Agenda for the American People had concluded its business and is preparing its final report. The HPA will office in the AMA building but will not be a part of the AMA. A motion was made that ISMS make a contribution of $5000 for the first year of the HPA in 1987. The action was deferred to the next Board of Trustees meeting.

AWARDS/PRESENTATIONS

The Illinois State Medical Society was awarded the prestigious Golden Trumpet for its professional liability initiative. The award is on display in the ISMS reception area. The Publicity Club of Chicago presented the award to the Society in the governmental affairs category. The comprehensive campaign was composed of the distribution of 700,000 pieces of literature and of media coverage on the issue which reached an estimated 65,950,000 people, or 8.4 million adults in Illinois 8 times.

During the June 14 caucus of the ISMS Hospital Medical Staff Section, the representative for South Suburban Hospital presented a $15,000 donation to IMPAC from the medical staff. Ingalls and St. James Hospitals have since made similar contributions. In addition, IMPAC will be working with the HMSS to encourage such contributions from other hospital medical staffs.

INFORMATIONAL REPORTS

Informational reports were presented by the Third Party Payment Processes Committee, Council on Medical Service, Committee on Health Planning, Committee for the Impaired Physician, Task Force on Financial Aid to Medical Students, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section, IMPAC, Trustees, Speaker, and Secretary of the AMA Delegation.

NEXT MEETING

The next Board of Trustees meeting was set for September 20-21, 1986, at ISMS Headquarters.

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October 20-25, 1986
Specialty Review in General Surgery, Part I
October 27-November 7, 1986
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November 5-7, 1986
Fiberoptic Esophagogastric Endoscopy
November 10-12, 1986
Flexible Fiberoptic Sigmoidoscopy
November 15, 1986
Advances in Internal Medicine, 1986
November 17-21, 1986
Specialty Review in Thoracic Surgery
January 5-10, 1987

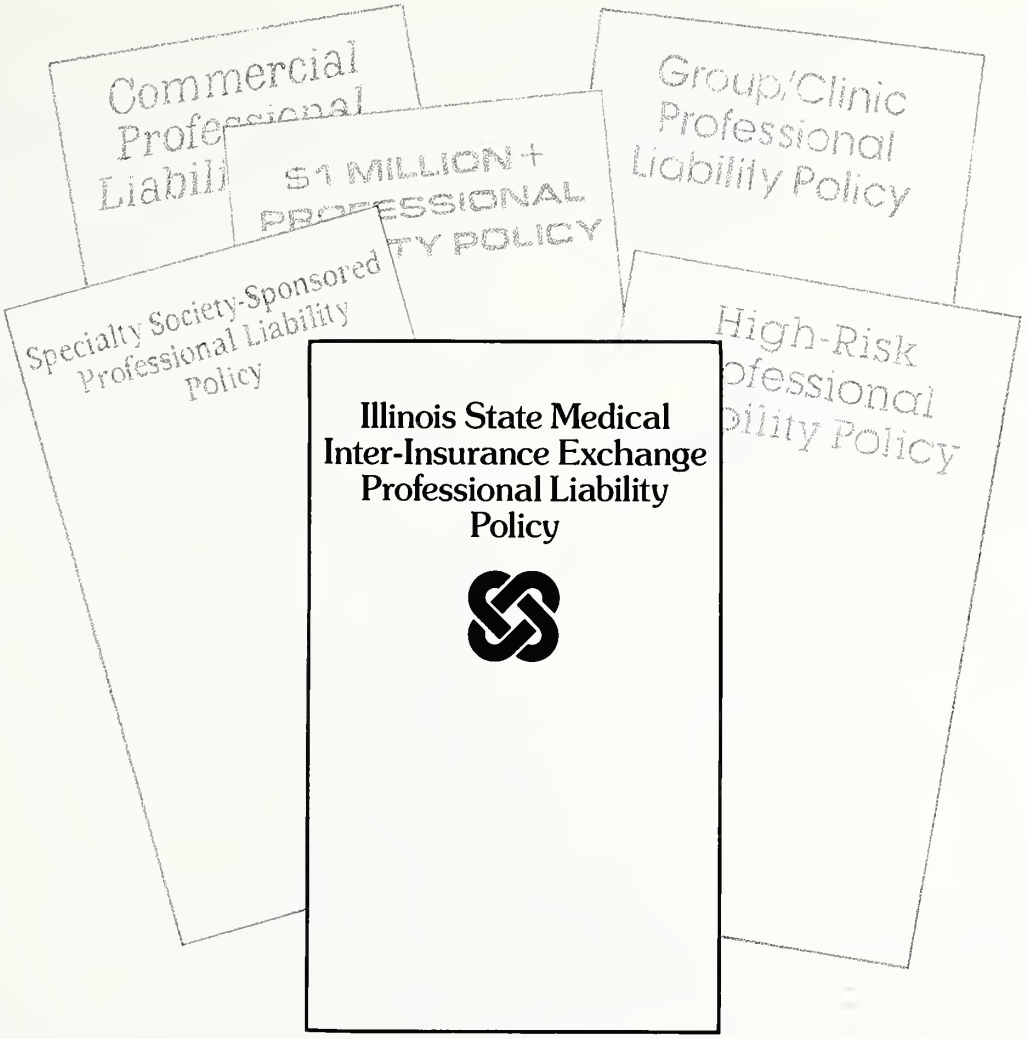
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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education (DRE)

Disciplinary Orders

- *Kyo Jin Cho* (lic. #036-045612)
  Effective April 12, 1986, Dr. Cho's medical license was placed on a one-year probation.
- *Barrett L. Coleman* (lic. #036-042289 & 003-036-042289)
  Effective April 22, 1986, Dr. Coleman's medical license was placed on probation for not less than three years and his controlled substance license was suspended for not less than one year.
- *William W. Dishuk* (lic. #036-46885)
  On May 13, 1986, Dr. Dishuk's medical license was temporarily suspended, pending a later hearing.
- *John Kitakufe* (lic. #036-060163 & 003-036-060163)
  Effective April 12, 1986, Dr. Kitakufe's medical and controlled substance licenses were revoked.
- *Vinod C. Patwardhan* (lic. #036-049616)
  Effective April 15, 1986, Dr. Patwardhan's medical license was indefinitely suspended.
- *Luis G. Perez-Reyes* (lic. #036-039088)
  Effective April 17, 1986, Dr. Perez-Reyes' medical license was restored and placed on a 3-year probation.
- *Thomas E. Porter* (lic. #036-042911 & 003-036-042911)
  Effective April 7, 1986, Dr. Porter's medical license was placed on a 2-year probation and his controlled substance license was suspended, with the suspension stayed and the controlled substance license placed on probation.
- *Mitchell Sokoloff* (lic. #036-025567)
  Effective April 15, 1986, Dr. Sokoloff's medical license was suspended for 6 months and subject to a probationary period.
- *Anna M. Wieland* (lic. #036-038241)
  Effective May 13, 1986, Dr. Wieland's medical license was suspended for an indefinite period.
- *Caecilia Winkler* (lic. #036-033525)
  Effective April 27, 1986, Dr. Winkler's medical license was placed on an inactive status with certain conditions.

(Source: Orders received from the Director of DRE)

From the Department of Transportation (DOT)

The DOT has developed a brochure to assist physicians in determining when it would be appropriate to grant a medical exemption from the new Illinois mandatory seat belt law.

The agency consulted with ISMS and several other medical and public health organizations in designing a pamphlet titled "Medical Guidelines for Safety Belt Use." Copies of this brochure are available free of charge to any physician by writing to Susan Wilson Rani, R.N., Occupant Restraint Coordinator, Department of Transportation, 2300 South Dirksen Parkway, Springfield, IL 62764, or by calling 1-800-423-2455.

(Source: Correspondence from DOT)

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National Auxiliary Action

By Lynn Kassel (Mrs. Wayne), ISMSA President-Elect

Honorable Maureen Reagan lent support and motivation to the power of women in her comments during opening ceremonies at the 63rd annual session of the AMA Auxiliary House of Delegates. Ms. Reagan's energetic portrayal of that power through anecdotes revolving around her post as the United Nations' representative reporting on the status of women, set the tone for that June 15-18 meeting. With the installation of the new AMA Auxiliary President, Pat Durham of Texas, the delegation was "challenged to change." The ammunition for change was delivered to the House, and judging from the reports of the '85-'86 state presidents, the challenge had been accepted in advance.

Illinois has a special challenge this year with the installation of St. Clair County's Betty Szewczyk as AMA Auxiliary president-elect. The incentive to increase our membership and top the six new counties Texas brought to this year's meeting is strong. Pat Durham's emphasis on members-at-large underscores Illinois' potential to increase membership. We are hopeful that ISMS and the county medical societies will assist the Auxiliary in membership recruitment efforts. There are 87 counties with organized medical societies in Illinois and only 28 organized auxiliaries. Our potential is enormous!

Diane Hinderliter from Ogle County was appointed a director for the North Central Region. Suzanne Meirink of St. Clair County will oversee the North Central States on the AMAA membership committee. All of auxiliary will be asked to participate in the membership drive under the direction of the ISMSA president, Pat Spadoni and first vice-president, Sherry Betsill.

Health concerns were demonstrated through the reference committees' recommendation of the following resolutions.

—Education on Danger of Smokeless Tobacco Products (Ohio)

—Education on and the Prevention of Severe Injuries Due to Shaking a Child (California)

—Education on Reducing the Risk of Osteoporosis (Arizona)

—Education on the Prevention of Skin Cancer (Arizona)

—Promotion of and Involvement with the Healthy Mothers, Healthy Babies Coalition (Montana)

—Mandatory Comprehensive Health Education Program (Including the Subject of Tobacco) in Elementary and Secondary Schools (West Virginia)

—Banning of or Health Warnings on Billboard Advertisements of Smokeless Tobacco Products (West Virginia)

Mini-briefing sessions were held on Sunday, prior to the opening ceremonies. Barbara Newman from Illinois' Adams County gave a comprehensive illustration of our teen suicide program, generating much interest and many requests for more information. As a result of this exposure, Barbara and her husband, Dr. Richard Newman, have been solicited for programs from other states.

West Virginia presented an excellent program on family life education at the health session, as

(continued on page 90)

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Cryopreservation of Human Spermatozoa

By Rajasingam S. Jeyendran D.V.M., Ph.D. and Mariano Perez-Pelaez, M.D./Chicago

Cryopreservation of semen is the process by which spermatozoa are sustained in a state of cryptobiosis (suspended animation) without affecting biological capabilities. A convenient form of semen preservation for artificial insemination, it also could potentially become a means of "fertility insurance" for men planning to be vasectomized or undergoing radiation or chemotherapy treatment.

Cryopreserved spermatozoa should be fertile. Successful preservation results in spermatozoa that will survive for a period of time in the female reproductive tract, undergo membrane changes such as capacitation and acrosome reaction, and release enzymes essential for fertilization. Various physiological, biochemical, and ultrastructural properties of spermatozoa must be preserved, necessitating supplementation or control of many factors during cryopreservation.

The initial quality of semen is of utmost importance. Cryopreservation preserves the existing quality of spermatozoa; it does not improve it. Semen should also be selected on the ability of the spermatozoa to withstand the stress of cryopreservation.

At this writing, little information is available regarding the optimum number of spermatozoa needed to facilitate human pregnancy. Colton and Farris[1] state that at least 20×10^6 motile spermatozoa are required to ensure pregnancy. Our limited experience suggests that a much lower number of spermatozoa is required, although this may depend upon several factors, such as timing, number, and site of insemination.

Semen Extenders

The purpose of an extender during cryopreservation is to preserve the fertilizing capacity of spermatozoa and increase the number of possible insemination doses. An extender maintains proper osmolality and pH during freezing and thawing.[2] In addition, it contains macromolecules (lipoproteins) and cryoprotectants, which protect spermatozoa against the stress of cooling and freezing. Zwitter ionic buffers[3] increase permeability of cell membrane, and are beneficial for survival during the long variation in osmolality and pH that occurs during freezing and thawing.

Human semen can be cryopreserved in glycerol only.[4] It should be noted that the first reported pregnancy was a product of frozen thawed semen that had been cryopreserved in glycerol only. Pace and Graham,[5] showed that low density lipoprotein fraction of the chicken egg yolk provides more cryoprotection to spermatozoa than glycerol in a zwitter ionic buffer system. The macromolecules of the egg yolk coat the sperm surface and, at least in bull semen, there appears to be an immunologically distinct, complex formation between seminal plasma proteins and egg yolk macromolecules.[6] This coating of egg yolk macromolecules on the sperm surface may also affect the membrane permeability of salts and water during freezing, just as the degree of sperm coating affects sodium and potassium transport across the membrane. Polymeric compounds other than lipoproteins provide very little cryoprotection to the spermatozoa.[7]

Freezing and Thawing of Semen

Success depends greatly on the water permeability of the cell membrane. The addition of cryoprotective agents appears to widen the

tolerable range of the rate of freezing. Although the optimum rate of freezing for human spermatozoa is not known, success has been claimed for a wide range. The recommended rates of freezing for human spermatozoa range from very slow, (1°C/min)[8] to moderate, (5 to 10°C/min)[9] to very fast (16 to 25°C/min).[10]

Generally, the rate of freezing is calculated as the difference in temperature divided by the time taken. However, freezing does not take place at a constant rate, and the rate decreases as the difference in temperature between the samples and the freezing environment decreases. The drop in temperature will follow an exponential curve rather than a straight line.

Graham, *et al.*,[11] demonstrated the differences in the rates of freezing at various temperatures. Their findings indicate that the maximum rate of freezing for pellet and ampule methods is 100°C/min, while the straw method rate is 170°C/min. In all three methods, maximum rates were between −10°C and −35°C. This is the critical temperature range[12] within which the greatest amount of damage occurs. It appears that a fast freeze rate at this range is less detrimental to spermatozoa and the effects due to freeze rates beyond −35°C will be minimal. Frozen semen cannot be maintained at this temperature, since ice recrystallization will injure the sperm. Water molecules attain a stable phase transition only below −140°C. For this reason, a frozen sample should be maintained at the temperature of liquid nitrogen (−196°C).

Thawing of semen should be done at as rapid a rate as possible. However, optimum freeze rate may depend on the thaw rate to be used.

Packaging of Frozen Semen

The three most common packages or containers for freezing semen are ampules, straws and pellets. Good recovery can result from any of these packages and the choice is largely based on personal preference. Generally, human semen has been frozen in easily-labeled flame-sealed glass ampules. However, the thickness of the glass and the geometry of the sample make very high freezing or thawing rates difficult. Ampules have been known to break or explode during rapid thawing. Plastic straws, although not commonly used in human semen preservation, have many advantages over ampules. Straws are easily labeled and sealed and can tolerate high freezing and thawing rates. Pelleted semen is the least common method of the three. Pellets are formed by placing a drop (0.1ml) of semen directly on a surface of dry ice. The main advantage of this method is the consistency of freeze rates due to the constant temperature of the surface of dry ice. The storage container should be as small as possible to facilitate controlled freezing. It also should be large enough to accommodate volume and shape for labeling.

Fertilizing Capacity of Cryopreserved Spermatozoa

Reports have indicated that cryopreserved human semen is less fertile than unfrozen semen.[3,13-15] Evidence indicates that glycerol, the most commonly used cryoprotective agent for human semen, may have an adverse effect on fertility in nonhuman species. Boar and turkey spermatozoa cryopreserved in glycerol showed a reduced fertility rate, although a reasonable recovery of motile spermatozoa was obtained.

Our studies tend to support the premise that glycerol may not be an optimal cryopreservative agent for human spermatozoa. We found that the spermatozoa cryopreserved in glycerol yielded significantly lower post-thaw motility and penetration of denuded hamster oocytes than nonfrozen sperm.[15] In addition, considerable ultrastructural and biochemical changes in the acrosome were observed following glycerol cryopreservation.[3,16,17] We postulated that human spermatozoa treated with glycerol develop a dependency to glycerol, and the subsequent removal of glycerol decreases motility as well as ability to penetrate denuded hamster oocytes.[15] No statistical difference was found between the oocyte penetration rates when the cryopreserved spermatozoa were either treated with glycerol or untreated (semen frozen with no additives).[18] Since cervical mucus prevents most, if not all, of the seminal fluid from entering the cervical canal,[19] it is likely that glycerol is also removed from the spermatozoa by the mucus. Therefore, an extender containing no[3] or minimal amounts[20] of glycerol may be more beneficial to human spermatozoa during cryopreservation than glycerol alone.

Conclusion

Although cryopreserved spermatozoa have been shown to have a reduced fertility rate, continued work with new techniques and procedures will eventually result in improved fertility, possibly reaching the values of fresh spermatozoa. The basic concepts of freezing and thawing should be familiar to all clinicians involved with human fertility, in order that the future of cryopreservation results not in its replacement, but its advancement. ◀

References

1. Colton, S.W. and Farris, E.J.: "Low Temperature Preservation of Human Spermatozoa with Practical Implications," *J. Urol.* 80:44, 1958.
2. Jeyendran, R.S., Graham, E.F.: "Effects of Cooling and Freezing on pH of Semen Extender," *Cryobiology* 19:16, 1982.
3. Jeyendran, R.S., Van der Ven, H.H., Kennedy, W.P., Perez-Pelaez, M., Zaneveld, L.J.D.: "Comparison of Glycerol and a Zwitter Ion Buffer System as Cryoprotective Media for Human Spermatozoa. Effect on Motility, Penetration of Zona-Free Hamster Oocytes, and Acrosin/Proacrosin," *J. of Andrology* 5:1, 1984.
4. Bunge, R.S., Sherman, J.K.: "Fertilizing Capacity of Frozen Human Spermatozoa," *Nature* (Lond) 172:767, 1953.
5. Pace, M.M., Graham, E.F.: "Components in Egg Yolk which Protect Bovine Spermatozoa During Freezing," *J. Anim. Sci.* 39:114, 1974.
6. Jeyendran, R.S. and Hunter, A.G.: "Properties of the Bovine Seminal Plasma Egg Yolk Protein Interaction Complex Formed During Cryopreservation," *9th Int. Congr. of An. Reprod. and A.I.*, Madrid, Spain. Vol V:375, 1980.

7. Jeyendran, R.S. and Graham, E.F.: "An Evaluation of Cryoprotective Compounds on Bovine Spermatozoa," *Cryobiology* 17:458, 1980.
8. Freund, M. and Widerman, J.: "Controlling and Recording Rates of Freezing and Defrosting of Human Semen," *J. Appl. Physiol.* 18:407, 1963.
9. Matheson, G.W., Carlsborg, L. and Gemzell, C.: "Frozen Human Semen for A.I.," *Am. J. Obstet. Gynecol.* 104:495, 1969.
10. Perloff, W.J., Steinberger, E. and Sherman, J.K.: "Conception with Human Spermatozoa Frozen by Nitrogen Vapor Technique," *Fertil. Steril.* 15:501, 1964.
11. Graham, E.F., Crabo, B.G. and Pace, M.M.: "Current Status of Semen Preservation in the Ram, Boar and Stallion," *XII Biennial Symposium on Animal Reproduction* 47(11):80, 1978.
12. O'Dell, W.T., Almquist, J.O. and Marsh, L.A.: "Freezing Bovine Semen. 111. Effect of Freezing Rate on Bovine Spermatozoa Frozen and Stored At −79°C," *J. Dairy Sci.* 41(1):79, 1958.
13. Amelar, R.D. and Dubin, L. "Frozen Semen—A Poor Form of Fertility Insurance," *Urology* 14:53, 1979.
14. Richter, M.A., Haning, R.V. and Shapiro, S.S.: "Artificial Inseminations: Fresh Versus Frozen Semen; the Patient As Her Own Control," *Fertil. Steril.* 41:277, 1984.
15. Jeyendran, R.S., Van der Ven, H.H., Perez-Pelaez, M. and Zaneveld, L.J.D.: "Effect on Glycerol and Cryopreservation on Oocyte Penetration by Human Spermatozoa," *Andrologia.* 17(3):241, 1985.
16. Heath, E., Jeyendran, R.S., Perez-Pelaez, M. and Sobrero, A.J.: "Ultrastructural Categorization of Human Spermatozoa Cryopreserved In Glycerol and In TESTCY," *Int. J. Andrology* 18:101, 1985.
17. Joyce, C., Jeyendran, R.S. and Zaneveld, L.J.D.: "Release, Extraction and Stability of Hyaluronidase Associated with Human Spermatozoa. Comparison with the Rabbit," *J. of Andrology* 6(3):152, 1985.
18. Jeyendran, R.S., Van der Ven, H.H., Perez-Pelaez, M. and Zaneveld, L.J.D.: "Non-Beneficial Effects of Glycerol on the Oocyte Penetrating Capacity of Cryopreserved Human Spermatozoa," *Cryobiology* 22:434, 1985.
19. Hafez, E.S.E.: "Transport and Survival of Spermatozoa in the Female Reproductive Tract," *Human Semen and Fertility Regulation in Man.* Ed. ESE Hafez, CV Mosby, St. Louis. p. 107, 1976.
20. Lucena, E. and Obando, H. "Comparative Study of Glycerol Levels as Cryoprotective Agents of the Human Sperm," *Xth International Congr. Animal Reprod. and A.I. II:* 193, 1984.

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Streptococcus pneumoniae Cellulitis

By Robert M. Hinnen, M.D., David E. Trachtenbarg, M.D., Marcia A. Miller, Ph.D., and John J. Coon, M.D.

Streptococcus pneumoniae *is a rare cause of cellulitis in adults. Only seven cases are reported in the literature.[1-6] Associated bacteremia was present in each. We report an additional case of pneumococcal cellulitis.*

A 78-year-old female was admitted with a 24-hour history of swelling and erythema which began at the left medial palpebral fissure and progressively involved the skin around the left eye, spreading over the left cheek and across the bridge of the nose. The patient complained of severe pain around the left eye. She reported one episode of nausea and vomiting the night prior to admission but denied fever, chills or previous upper respiratory tract infection. The patient gave a history of bilateral cataract extraction and wore hard contact lenses 14 to 16 hours daily.

Physical exam revealed an elderly female who appeared to be ill. Her blood pressure was 168/80, pulse 150 and oral temperature 39.5°C (103°F). Areas of bilateral periorbital edema, erythema and tenderness extended across the face in a butterfly distribution, down the left side of the face and over the mandible to the left anterior neck (Figure 1). The left upper and lower eyelids were very swollen and erythematous. A small amount of purulent discharge was noted in the left palpebral fissures. A fluorescein test revealed an area of uptake on the left cornea. Fundoscopic exam was normal. The tympanic membranes were normal with light reflexes bilaterally. The oropharynx was not inflamed. The neck was supple without lymphadenopathy. Lungs were essentially clear to auscultation and percussion. The remainder of the exam was within normal limits.

Hemoglobin was 11.7 and white blood cell count was 13,400 with 71% segmented neutrophils, 19% bands, 8% lymphocytes and 2% monocytes. Chest x-ray revealed a



Figure 1
Patient at the time of admission.



Figure 2
Patient after three days of antibiotic therapy.

Table One

Eight Cases of Pneumococcal Cellulitis in Adults

Author	Year	Age	Sex	Underlying disease	Affected skin	Pneumonia	Septicemia	Isolation of organism: blood	Isolation of organism: skin	Treatment	Result
Connio[1]	1917	25	M	None	Face, scalp	–	+	+	+	Arsenicals	Recovered
Lewis[2]	1975	21	M	Drug addiction	Leg	–	+	+	+	Clindamycin, gentamycin	Died
		41	M	Drug addiction	Hand	–	+	+	+	Clindamycin, gentamycin	Recovered
Milstein & Gleckman[3]	1975	86	F	Macroglobulinemia	Face, scalp	Pleural effusion	+	+	+	Penicillin	Died
McGavin[4]	1977	66	M	Pneumococcal pneumonia	Leg	+	+	+	–	Co-trimoxazole, lincomycin	Recovered
Varghese[5]	1979	18	M	Nephrotic syndrome	Face, scalp	–	+	+	N.A.	Penicillin	Recovered
Mujais[6]	1983	22	M	Nephrotic syndrome	Abdomen	–	+	+	N.A.	Penicillin	Recovered
Present case	1985	78	F	None	Face	Pleural effusion	+	+	+	Penicillin	Recovered

N.A. - Not Applicable

small left pleural effusion without pulmonary infiltrates. Paranasal sinus x-rays were normal. Gram stain of purulent discharge from the left palpebral fissure, aspiration of left cheek tissue fluid, and four blood cultures were positive for gram-positive cocci in pairs and chains, later identified as *Streptococcus pneumoniae.*

The patient was treated with intravenous penicillin G, two million units every four hours. A dramatic response was seen within three days. (Figure 2) Intravenous antibiotic therapy was continued for one week, followed by oral antibiotics to complete a two-week course.

Discussion

Connio[1] described a case of pneumococcal cellulitis in 1917 involving the face and scalp of a 25-year-old male. *Streptococcus pneumoniae* was isolated from the patient's skin and blood. The patient was treated with arsenicals and recovered.

Not until 1975 was another case reported, two cases by Lewis, *et al.*,[2] and one by Milstein and Gleckman.[3] Lewis reported cellulitis of the extremities in two male drug addicts. Pneumococcus was isolated from the skin and blood in both cases. The patients were treated with clindamycin and gentamicin. One recovered and one died.

Milstein and Gleckman[3] reported the case of an elderly female with macroglobulinemia who developed cellulitis of the face and scalp. Strep pneumoniae was again isolated from blood and skin. The patient was treated unsuccessfully with aqueous penicillin and died.

In 1977, McGavin and Clancy[4] reported a 66-year-old male who presented with right-sided pneumonia and cellulitis involving the left thigh. Cultures of sputum, blood and throat grew *Streptococcus pneumoniae.* Initial treatment was started with co-trimoxazole (trimethoprim-sulfa) because the patient was allergic to penicillin. Pus was aspirated from the left knee and also yielded pneumococci. Lincomycin was added to the therapeutic regimen on the third day because knee aspirates remained positive. Also on the third day, liquid was aspirated from bullae on the left thigh, but was sterile. This patient gradually recovered.

In 1979, Varghese, *et al,*[5] and in 1983, Mujais and Uwaydah,[6] each reported a case of a young man with nephrotic syndrome who developed cellulitis. Varghese described an 18-year-old male with facial and scalp cellulitis. Pneumococcus was isolated from the patient's blood. He was treated with aqueous penicillin and recovered.

The 22-year-old male reported by Mujais and Uwaydah[6] developed cellulitis involving the skin of the abdomen, groin, lower back and lower extremities. Three blood cultures grew *Streptococcus pneumoniae.* This patient also responded dramatically to intravenous penicillin G.

Conclusion

Associated bacteremia in all eight cases (Table 1), highlights the importance of obtaining blood cultures. We can only speculate as to the significance of the small pleural effusion in our patient and the patient described by Milstein and Gleckman.[3] The finding of a small corneal abrasion was unique to our patient. Its role in development of the patient's cellulitis and bacteremia is undetermined.

Pneumococcus may be more common than previously suspected, because pneumococcal cellulitis responds to the usual therapy for streptococcus and staphlococcus, and positive cultures are often difficult to obtain. These cases also demonstrate the importance of associated underlying conditions, including immunoincompetence, nephrotic syndrome, and respiratory infections. Most patients with pneumococcal cellulitis will recover with appropriate antibiotic treatment.

References

1. Connio, A.: "Diplococcal Erysipelas with Septicemia," *La Reforma Medica* 33:709-712, 1917.

2. Lewis, R.J., Richmond, A.S., McGory, J.P.: *"Diplococcus Pneumoniae* Cellulitis in Drug Addicts," *JAMA* 232:54-55, 1975.
3. Milstein, P., Gleckman, R.: "Pneumococcal Erysipelas," *Am. J. Med.* 59:293-296, 1975.
4. McGavin, C.R., Clancy, L.J.: "Cellulitis in Complicated Pneumococcal Pneumonia," *Br. J. Dis. Chest* 71:213-214, 1977.
5. Varghese, R., Melo, J.C., Chun, C., Raff, M.J.: "Erysipelas-Like Syndrome Caused by *Streptococcus Pneumoniae," Southern Med. J.* 72(6):757-758, 1979.
6. Mujais, S., Uwaydah, M.: "Pneumococcal Cellulitis," *Infection* 11:173-174, 1983.

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A Successful Experiment

A Unique Residency In General Surgery

By Robert L. Schmitz, M.D. and Lloyd M. Nyhus, M.D./Chicago

This is a description of a 13-year-old residency training program in general surgery affiliated with a major medical school and involving five community hospitals. Its apparent success recommends it as a prototype for similar endeavors.

The Metro Group Hospital Residency in General Surgery was conceived in 1971. The University of Illinois had already started an undergraduate Metropolitan Group Hospitals (MGH) rotation to six Chicago area community hospitals. This functioned as a medical school without walls in which the students rotated through the various hospitals during the clinical years. In addition, the University Academic Council was working to implement the Corporate Responsibility for Medical Education Program. To help regulate and develop the undergraduate program, each department had a joint conference committee composed of representatives from each MGH affiliate and the university departments. When the undergraduate programs were well underway, the joint conference committee in surgery began to consider a surgical residency involving the MGH. Two of the hospitals already had four-year programs. The others were approved for one or two years of training. A five-year residency was designed which would train surgeons by rotating them through all MGH affiliates (then six in number). The plan was submitted to the Conference Committee on Graduate Education in Surgery and provisionally approved in June, 1972. The MGH residency in general surgery of the University of Illinois became a functioning entity on July 1, 1973.

Fifty-two (52) residents, 14 PGY1, 14 PGY2, 8 PGY3, 8 PGY4 and 8 PGY5, formed the nucleus of the first classes. These first residents were chosen from those already in the various hospital programs, plus "fill-ins" picked up from other programs.

In mid-1974, we had our first on-site review by the residency review committee in surgery. We received probationary approval from the Liasion Committee on Graduate Medical Education (LCGME). In addition, we held our own internal review, and as a result, a number of changes were gradually implemented. The number of residents was reduced from 52 to 40, and then to 30. The number of chief residents was reduced from eight to six, and then to four. One of the hospitals was dropped after it lost its residency in internal medicine.

Educational features were strengthened by instituting the following measures:

- A weekly journal review using reprints from the University of Texas Southwestern Medical School at Dallas selected readings. Staff and residents at all hospitals review the same topics so that the residents remain in step throughout institutional rotations.
- Administration of a weekly written quiz patterned after the Self Education Self Assessment Program (SESAP) of the American College of Surgeons. This was designed to expose trainees and to alert the chairmen to any deficiencies in knowledge requiring remedial attention.
- Verbal exchange between the audience and resident panelists at monthly journal club meetings.
- Participation in the in-training examination of the American Board of Surgery. The grades

Table 1
University of Illinois College of Medicine at Chicago Metropolitan Group Hospitals Residency in General Surgery

Metro Sponsored Visiting Professors	
December 1-2, 1978	Arthur C. Beall, Jr., M.D., Baylor College of Medicine
February 2-3, 1979	Louis Del Guercio, M.D., New York Medical College
March 23-24, 1979	Robert J. Baker, M.D., University of Illinois
April 6-7, 1979	F. Henry Ellis, M.D., Lahey Clinic—Boston
May 3-5, 1979	Oliver H. Beahrs, M.D., Mayo Clinic
June 2, 1979	M. S. Elliot, M.D., Groote Schuur Hospital and University, Capetown, South Africa
October 5-6, 1979	Norman M. Rich, M.D., Walter Reed Army Hospital
November 2-3, 1979	Denton Cooley, M.D., Texas Heart Institute
February 1-2, 1980	W. Spencer Payne, M.D., Mayo Clinic
March 7-8, 1980	S. Arthur Localio, M.D., New York University Medical School
December 5-6, 1980	Charles McBride, M.D., M.D. Anderson Hospital and Tumor Institute, Houston, Texas
December 12-13, 1980	Marshall J. Orloff, M.D., University of California, San Diego, California
February 6-7, 1981	John S. Najarian, M.D., University of Minnesota Medical School, Minneapolis, Minnesota
March 6-7, 1981	Thomas E. Starzl, M.D., University of Pittsburgh
April 3-4, 1981	William ReMine, M.D., Mayo Clinic, Rochester, Minnesota
November 6-7, 1981	James A. DeWeese, M.D., University of Rochester Medical Center, Rochester, New York
February 5-6, 1982	Hermes C. Grillo, M.D., Harvard Medical School
March 5-6, 1982	Basil A. Pruitt, Jr., M.D., Brooke Army Medical Center, Ft. Sam Houston, Texas
November 4, 1983	Thomas L. Petty, M.D., University of Colorado Health Sciences Center
December 2-3, 1983	Donald Trunkey, M.D., University of California, San Francisco and San Francisco General Hospital
February 3, 1984	Anthony M. Imparato, M.D., New York University Medical School
April 6, 1984	Ben Eiseman, M.D., University of Colorado Health Sciences Center

become a part of resident overall evaluation.

- Regular attendance and participation in the weekly x-ray conferences and weekly grand rounds held at the University of Illinois College of Medicine. Our residents present cases regularly. The MGH has played an active role in the visiting professorship program of the university. (Table 1)

In the spring of 1977 we had our second external review by the residency review committee. The liaison committee continued probationary accreditation for two more years.

Shortly after the 1977 review, we felt that we were ready for full accreditation, and requested another (early) review with that in mind. We were visited in September, 1978, and subsequently received accreditation "without qualification for five years of graduate medical education in surgery" from the LCGME.

Our most recent review was during the spring of 1982 and the Accreditation Council for Graduate Medical Education (ACGME) (which replaced the LCGME) continued accreditation without reservation.

Educational Goals

Our aim was to produce surgeons competent to practice all branches of general surgery, including head and neck, breast, alimentary tract, abdomen, peripheral vascular system and integument. We also sought to provide adequate exposure to subspecialties, including plastic, thoracic, cardiovascular, gynecology, genitourinary, orthopedics, neurosurgery and pediatric surgery.

It is understood that each graduate of the program will be qualified to write the examinations for certification of the American Board of Surgery.

Program Design and Content

There are five hospitals in the program: Illinois Masonic Medical Center, Louis A. Weiss Memorial Hospital, Lutheran General Hospital, MacNeal Memorial Hospital and Mercy Hospital and Medical Center.

At present we have 30-32 residents spread over five PGY levels. We match eleven PGY1s with the National Resident Matching Program (NRMP). Five are matched in general surgery and six in surgical subspecialties. The latter are encouraged to take two years of a core curriculum in general surgery. There are four residents at each of the PGY3, 4 and 5 (chief) levels.

Each participating hospital offers training in general surgery. Illinois Masonic also offers head and neck, urology, thoracic and anesthesia rotations in the second year. Louis A. Weiss Memorial offers critical care in the second year and pathology for PGY1 residents. Lutheran General provides a pediatric rotation in the third year, and a gynecologic residency in the second. MacNeal Memorial offers a peripherovascular rotation in the third year. Cardiovascular and thoracic in the third year, orthopedics and critical care in the second, and neurosurgery, plastics, emergency medicine and cardiovascular thoracic rotations in the first year are available at Mercy.

Residents are accepted at PGY1 directly after finishing medical school. Trainees complete rotations in general surgery and various subspecialties at all hospitals. They rotate every two months at PGY1 and 2 and every three months at

PGY3, 4 and 5. Housing is available at each of the hospitals, or the resident may choose his own "home."

At the first and second levels, the residents are exposed to general surgery, neurosurgery, plastic surgery, urology, orthopedic surgery, anesthesia, surgical pathology, cardiovascular, thoracic and gynecologic surgery.

Starting at the third level, the resident is introduced to longer periods of time in general surgery, but also participates in peripherovascular, cardiovascular, head and neck and pediatric surgery. Before the third year, the five eligible residents are screened by the individual program chairmen as well as the surgical joint conference committee, to select the four who are to continue. Every effort is made to place the extra resident in a satisfactory program.

During training, the resident is given increasing patient responsibility, both inpatient and outpatient. Residents who prove to be excellent physicians, well-acquainted with the basic sciences and therapeutics, with technical ability to perform surgery, are gradually introduced to the position of surgeon-in-charge of the patient. This usually occurs at the fourth level.

After a very short initial period in the fourth level of education, the resident performs, under direct supervision, the majority of the surgical work of the particular service. At this point, the resident is allowed to make decisions, but must justify all evaluations, conclusions and surgical procedures with an attending staff surgeon.

The fifth-year level is the chief residency year. The resident assumes administrative responsibility and a greater teaching load, has independent operating privileges and performs about 300 major operations.

Table 2
Teaching Elements Common to All Residents and Facilities

(1)	Weekly clinical radiological correlation conferences—University of Illinois College of Medicine
(2)	Weekly grand rounds—University of Illinois College of Medicine
(3)	Weekly surgical pathology conference
(4)	Weekly basic science conference
(5)	Weekly morbidity and mortality conferences
(6)	Weekly selected readings from The University of Texas Southwestern Medical School at Dallas (2 hr/week)
(7)	Written examinations
(8)	Oral examinations
(9)	Monthly journal club
(10)	Visiting professor program

Surgical Experience

Each resident does about 800-1000 major operations of wide variety during the five years. Ordinarily, 400-700 are completed in the first through fourth years and 200-300 in the chief year. In addition, he or she assists at 500 more surgeries. These experiences are documented in a "Resident's Log" and totalled on forms furnished by the American Board of Surgery.

Teaching Exercises and Experience

Teaching exercises common to all residents at all hospitals are detailed in Table 2. In addition, each MGH affiliate has its own teaching rounds and conferences. Basic science data are incorporated in educational presentations at all levels: undergraduate, graduate and CME. A basic science review presented by the residents and monitored by attending surgeons is held once a week. The residents are actively involved in teaching the undergraduates at all levels.

Research and Investigation

All residents are encouraged to write at least one paper during their tenure involving clinical reviews and/or statistical studies and, on occasion, "bench research."

Outpatient Experience

All MGH hospitals have outpatient clinics. In these departments, the resident is the primary physician and the responsible attending surgeon acts as a consultant. Together, they make the diagnosis, admit the patient and prepare him or her for surgery, conduct surgery and participate in follow-up and rehabilitation.

Emergency Room Service

All MGH affiliates have active emergency services. These services are manned by the residents, who have access to an attending physician on call. The patients are admitted by the "team" on call. The team conducts surgery and follow-up. The resident acts as primary physician.

Evaluation

A quarterly review of the resident's record evaluates progress, and weaknesses are analyzed. In addition, the residents evaluate the attending staff after each rotation. This is valuable to structuring the curriculum.

At each monthly joint conference committee meeting, the directors review each resident to measure progress and suggest corrective action for any deficiencies. The residents are advised promptly of any criticism and/or suggestions.

Residents

At this writing a total of 42 graduates have completed the program. Forty graduates have written the American Board of Surgery qualifying examination and 38 have passed. Thirty-four have taken the certifying examination and 34 have passed.

Twenty graduates are fellows of the American College of Surgeons. Eight have been accepted into advanced fellowships for subspecialty training. Eight have been appointed to the faculties of the MGH hospitals, and six hold medical school appointments. Thirteen have been published in refereed journals.

The Future

We have recently completed another internal review, and several changes in the program are planned. More emphasis is being placed on involvement of the residents in pre-operative decision-making and patient follow-up. We also plan to give greater emphasis to clinical research by both attending physicians and residents.

We hope that this description of our program in the arena of private

practice will encourage others to follow, enabling our residents to broaden their exposure to private patients. Programs such as this keep the quality of medical care in community hospitals at a high level. Finally, we have demonstrated that good training programs in non-university and non-public care hospitals can be a reality. They should be not only perpetuated, but expanded as part of the corporate responsibility of a university. ◀

Lloyd M. Nyhus, M.D., a board certified surgeon, is the Warren H. Cole professor and head of the department of surgery, University of Illinois College of Medicine at Chicago. The surgeon-in-chief at the University of Illinois Hospital and a member of the board of governors of the American College of Surgeons, Dr. Nyhus is a past president of the International Society of Surgeons, the Chicago Surgical Society and the Central Surgical Society. The present editor-in-chief of *Current Surgery*, he has served on the editorial boards of several national medical journals, and is widely published.

Robert L. Schmitz, M.D., is the director of medical education and chairman of the department of surgery of Mercy Hospital and Medical Center, Chicago. A fellow of the American College of Surgeons, he is program director for the Metropolitan Group Hospitals residency in general surgery. A professor of surgery at the University of Illinois College of Medicine, Dr. Schmitz is past president of the Mercy Hospital medical staff, the Chicago Surgical Society, the Illinois Surgical Society, the University of Chicago Medical Alumni Association, the Illinois Division, American Cancer Society, the Interagency Council on Smoking and Health, and the American College of Surgeons, Metropolitan Chicago Chapter. A past president of the Illinois Division, he serves on the national board of directors for the American Cancer Society.

Pulse

(continued from page 78)

did Georgia with a program for child abuse prevention.

Unified membership was the subject of an important resolution from the Reference Committee on Bylaws Amendments. All states with 75% or more unified members can receive recognition of that percentage by requesting it in writing by January 1. Illinois has been a unified state (requiring membership in county, state and AMA) for a number of years, and five states have unified membership now.

Last year's membership challenge to Ohio and Illinois ended without a winner. Although Ohio increased membership, they did not increase AMA members (not a unified state) so we did not lose. They did pass a crying towel to us, and we provided T-shirts from the University of Illinois to remind them that the "Fighting Illini" were still working hard.

State presidents' reports always remind the delegation of the hard working volunteers throughout this nation representing organized medicine. Listening to the amazing results of volunteer efforts emphasized Maureen Reagan's message: the power of women. A few of the highlights in these reports are listed below.

—AMA-ERF raised $1.8 million this year and 75% was raised by auxiliary.

—New Jersey, with the third highest number of AIDS victims in the United States, put together an educational program in Hudson County.

—"Just Say No" club was established to fight drug/alcohol pressure on teens in Washington, D.C.

—State after state marched to their state capitols to legislate tort reforms, many modeled after Illinois.

—Nebraska declared war on colon-rectal cancer . . . it is #1 in the nation in victims of this disease.

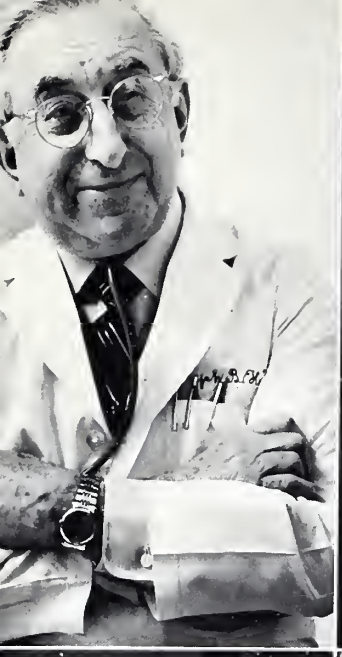
—Wisconsin and Minnesota both focused on teen pregnancy/sexuality programs.

—Utah has a group of singing auxilians visiting nursing homes.

—Alabama founded a summer camp for children with cancer. They also assist the medical auxiliary in Guatemala.

—Florida designed a highly publicized program on missing children in conjunction with the national center in D.C.

Illinois celebrated the installation of Betty Szewczyk with a small reception in her honor June 17th. All Illinois will celebrate next June as Betty leads Illinois and the nation in 1987. Plan to organize programs and membership now to demonstrate the leadership of Illinois auxilians. ◀

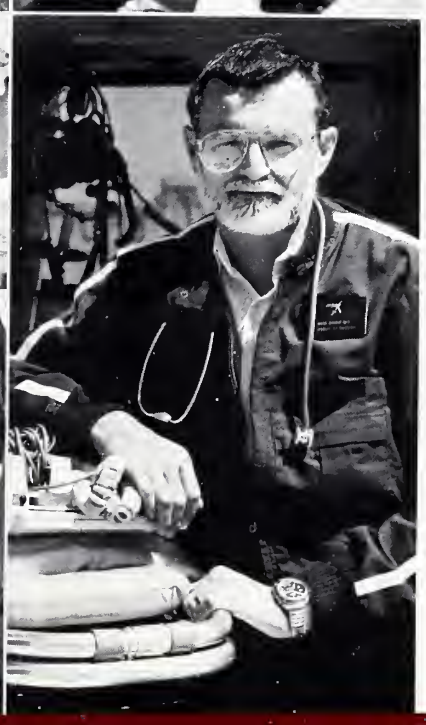












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A Country Doctor of Adventuresome Spirit

Charles Ellet Lippincott

By Emmet F. Pearson, M.D./Springfield

Dr. Charles Ellet Lippincott was a remarkably adventurous and ambitious man of the stimulating and historic Civil War era. Lippincott received most of his higher education at Illinois College in Jacksonville and at the Illinois College School of Medicine. These institutions were, respectively, the first college and the first medical school in Illinois. After a few years of country practice, he joined the gold seekers in California, where he eventually became a prominent politician and state senator. After an infamous duel, Lippincott left California and became involved in the Civil War, where his heroism earned him the rank of brigadier general.

Charles Ellet Lippincott was born on January 26, 1825, in Edwardsville, Illinois. His father was a prominent clergyman and one of the original founders and trustees of Illinois College at Jacksonville. Edwardsville was the home of Illinois' first governor, Benjamin Edwards.

Charles more than compensated for his admittedly homely appearance by showing himself to be athletic, ambitious and bright. His father encouraged Charles in his studies, but was unable to finance a higher education, as he was burdened with the support of his wife and 11 children. For two years Charles worked for 12 dollars per month planting and harvesting grain and teaching in the winter.

In 1844, at age 19, he was admitted to Illinois College. While there, he became acquainted with Jacksonville Doctor David Prince, one of the world's first plastic surgeons, who later was to become quite famous. Dr. Prince was a founder and professor of anatomy and surgery at the Illinois College School of Medicine.

While in college, Charles became involved with a group of students who were promoting the Jacksonville underground railway, which was used to escort runaway slaves to northern territory. Jacksonville was a natural way-station for the underground railway, since it was also the home of Edward Beecher, brother of Henry Ward Beecher and Harriet Beecher Stowe, all active abolitionists.

On one occasion, while a student at Illinois College, Charles was punished for a misdemeanor by a Professor Turner, who tied him down with hands and legs bound to four legs of a table. He remained there for hours looking at a black snake whip. After he had shown some repentance, Charles was released and told that the professor could not strike the son of a founder and trustee of the college.

In 1845, Lippincott left school and, as was the custom, apprenticed himself to Dr. George Allen of Marine, Illinois, a physician who later became a medical inspector for the Union Army under General Grant. In 1847, he was admitted to Illinois College School of Medicine, barely managing to scrape together the $60 annual tuition. Due to financial problems, Charles dropped out of medical school and went to Alton to work for Godfrey and Gillan, a merchandising concern owned in part by his sister's husband.

It was said that the Reverend Elijah Lovejoy had operated a printing press in the warehouse of that firm, and published materials advocating abolitionism. Lovejoy had been murdered on November 6, 1837, by a posse, which had thrown his printing press into the Mississippi River.

When the Alton company moved to St. Louis, Charles moved also. With some help from Gillan, he was able to enroll as an advance student in the Pope Medical School, (sometimes referred to as St. Louis Medical School, a linear predecessor of Washington University) where he received an M.D. degree in 1849. In medical school, he wrote one notable essay entitled, "The Impalpable in Cure of Disease."



Charles E. Lippincott (center) as a colonel during the Civil War. He returned home a brigadier general and was greeted as a war hero. Reprinted with permission of the California State Library, Sacramento.

In looking for a place to practice medicine, Charles became acquainted with Dr. Charles Chandler, a physician who had recently moved from Rhode Island to near Beardstown, a thriving community on the Illinois River. Dr. Chandler was credited with introduction of quinine to treat malaria in Illinois. He was also among the first practitioners to advocate abolishing bleeding in medical treatment. Soon Charles began riding with Dr. Chandler on his rounds. The young apprentice quickly obtained a horse and bridle and saddlebag containing jallop, squires, blistering ointment and a lancet.

Thomas Beard, Beardstown's founder, showed Dr. Chandler an area a few miles inland from the Illinois River, which had been cleared to build a new town, to be called Panther Creek. Lippincott called on political friends, such as Stephen A. Douglas, to lobby to have the name of Panther Creek changed to Chandlerville, in honor of his patron. He also was successful in getting a post office established in the new town. Dr. Chandler then became postmaster. Dr. Chandler asked a young surveyor, a friend by the name of Abraham Lincoln, to come and survey the site of the new town.

Dr. and Mrs. Chandler had two pretty daughters, who as teenagers were sent to a new seminary at Monticello near Alton. After the second daughter, Emily, finished school at Monticello, she and Lippincott were married on Christmas Day of 1851.

Dr. Chandler had many business interests and soon turned over much of his practice to Lippincott, who became the leading practitioner in Cass County. Charles was more interested in the art than in the science of medicine. He preferred to practice what was called the aleopathic system. For a while he was a model Presbyterian, and against smoking, liquor and profanity, but later he exhibited different behavior. Lippincott became particularly distressed when another doctor settled in the vicinity and began competing for patients.

West Coast Departure

About this time, the Gold Rush to California was in full force and Charles' adventuresome spirit caused him to leave his wife with her family and take off to the far west. After taking the Overland Trail in a wagon pulled by oxen, he arrived in California in 1853 and quickly became a digger, broker, and promoter of gold mining.

Lippincott soon became involved in politics in the new state, which

had been admitted to the Union in 1850. California had been admitted as a non-slave state, but politics and arguments over the abolition question were furious. Former New Yorker David Broderich emerged as a chief advocate of abolitionism and

For a while he was a model Presbyterian, and against smoking, liquor and profanity, but later he exhibited different behavior.

became a candidate for the U.S. Senate from California. Charles joined the Broderick campaign and himself became a candidate for the state senate from Sierra County. Both men were elected as "free soil" advocates and Democrats.

Charles' life was to change as a result of a particular event which occurred on July 4, 1853, in the small town of Downieville. A large patriotic meeting was being held on that day. A young man, a lawyer named Robert Travis from Mississippi, who was a strong pro-slavery candidate for Congress with "know nothing" leanings, was asked to make introductory remarks. Travis proceeded to give a very long partisan speech that annoyed many listeners. Shouting began and cannons were fired to drown out his speech. As an editor of a local newspaper in Downieville called the *Sierra Citizen,* Lippincott wrote a short article chastising Travis for his speech. Travis, in turn, called Lippincott a liar, a coward and a slanderer. He demanded a denouncement of the article and an open apology. Lippincott had to decide quickly whether to be ostracized as a coward, leave the state or challenge a duel. He had not met Travis personally.

No one could discourage Travis from the duel. He chose double-barreled shotguns with one ounce lead balls as weapons. Travis' decision was an advantage to Lippincott, who had used the same weapons to shoot deer in Illinois.

The two parties had gone about six miles from town and were ready to be called into the duel when they heard the news that the sheriff was rapidly approaching. They quickly moved into another county where the sheriff had no authority. The opponents moved off thirty paces and were called on to fire. A ball went through Lippincott's hair and Travis' heart.

The shock of the death in this small community caused Lippincott to cross into Nevada for a while. When he came back to California, he was dropped as a candidate for re-election and public esteem for him waned. His friend Broderick, who had been elected to the U.S. Senate, was going to Washington, and Lippincott decided to go with him. After Lippincott saw Broderick installed, he returned to Chandlerville to rejoin his wife and family. He continued to practice medicine there for the next four years.

Return to the Midwest

Lippincott arrived back in Illinois during the famous Lincoln-Douglas debates and he freely made political speeches for his old friend Stephen Douglas, who proceeded to win the Senate seat. Lippincott was never a friend of Abraham Lincoln's. He continued to be a strong political promoter of Douglas in his presidential campaign against Lincoln. Needless to say, Lippincott was very displeased when Lincoln was elected.

On April 15, 1861, Illinois Governor Yates issued a call for 75,000 volunteers. Lippincott had once before left his wife in the care of her parents and he hesitated to volunteer. When the Confederates defeated the Union armies in the Battle of Bull Run, however, Lippincott raised 45 volunteers and reported to duty at Springfield's Camp Butler in July of 1861. He was soon elected to the rank of captain. Although he had had no military experience or knowledge, he was greatly enthusiastic and a violent abolitionist. At Camp Butler, the 33rd regiment soon came to be called the Normal regiment, because it was made up largely of students and professors and President Howie from Normal University near Bloomington.

Colonel Howie and Captain Lippincott took their troops into Missouri and soon encountered



Charles E. Lippincott, M.D., as a gold seeker in California, circa 1852. Reprinted with permission of the California State Library, Sacramento.

They quickly moved into another county where the sheriff had no authority. The opponents moved off thirty paces and were called on to fire. A ball went through Lippincott's hair and Travis' heart.

rebel forces under General Robinson in hand-to-hand combat. Captain Lippincott thrust his blunt saber against a rebel soldier, but to his chagrin, the saber did not go through the coat and the soldier fled.

A little later, when Lippincott returned to Springfield, he visited Governor Yates, who appointed him lieutenant colonel. In Missouri, he was again involved in many skirmishes. During one of these, he stole 300 bales of cotton from a farm and shipped them back to Illinois. By 1863, he had been promoted to full colonel and had a regiment of his own.

Colonel Lippincott led his regiment to join General Grant in the siege against Vicksburg, where he was badly wounded. When Vicksburg was captured, Lippincott was moved to Jackson, Mississippi, where he remained in the hospital for a time until his recovery. He then led his troops to New Orleans and on to Texas. After a long idle period, Lippincott and many of his troops were given leave for recuperation in Illinois. His troops reassembled and he returned to Louisiana and attacked a rebel stronghold at Spanish Fort near Mobile. This battle took place on the same day that Lee surrendered to Grant—April 4, 1865.

Return to Politics

Lippincott was mustered out of Vicksburg as brigadier general. He returned to Chandlerville a great war hero. About this time he was nominated for U.S. Congress by the Republican party. This move in itself was quite a coup, because he had been a Democrat until this point in his career. Although he was defeated for Congress, General Lippincott was made secretary of the Illinois Senate on the Governor's recommendation. The following year he resigned that position and went to Washington, D.C., as doorkeeper of the House of Representatives. This job was considered a political plum.

In 1858 the Republican party nominated and elected him state auditor of Illinois. The Illinois constitution at that time included a requirement that all officers must take an oath that they had never participated in a duel. Lippincott took the oath without reservation, on the justification he had fulfilled an honor and that what happened in California had no jurisdiction in Illinois. He also pointed out that Governor Bissell, the first Republican Governor of Illinois, had been involved in a duel and later swore that he had never accepted such a challenge. Lippincott was re-elected to office in 1872, but by this time the oath concerning duels had been withdrawn.

While he was state auditor, business was conducted under a generous fee system then in vogue, and his annual income was enormous. He invested quickly and extensively in real estate around Chandlerville, acquiring vast acreage. Lippincott also started a huge livestock business of purebred shorthorn cattle and riding horses. (In one case he paid $17,500 for a bull and $10,000 for a cow.) The Lippincotts purchased a large and lovely home in Springfield, where his delightful wife Emily entertained lavishly. The General was being considered a strong candidate for Governor. On at least one occasion, Lippincott hired a train to carry hundreds of his friends to his farm. On that trip they were served champagne and beef from his herd.

Lippincott became notorious for his great extravagance, to such an extent that his popularity diminished and he was not renominated for the auditor's position. Meanwhile, Illinois suffered a period of depression and Lippincott was forced to mortgage all of his property. His luck worsened. Among other things, his famous cow, "Duchess of York" was found infertile and his famous bull died. When his mortgage was foreclosed, Lippincott had to move from his home in Springfield back to the family home in Chandlerville. Forlorn and nearly destitute, Lippincott had a stroke, but made a good recovery.

In June of 1885 the Illinois State legislature established a home for honorably discharged soldiers and sailors who had enlisted in the army or navy in Illinois. This home was to be located in Quincy on the Mississippi River. As a result of Governor Oglesby's friendship and sympathy, General Lippincott was appointed to be the first governor of this home. He was very grateful and happy to have a new opportunity.

General Lippincott died in Quincy, on September 11, 1887, at the age of 62 following a second stroke. He left no estate. In deference to the elder statesman and war hero, Governor Oglesby ordered that the flag be held at half mast. Lippincott was buried at Oak Ridge Cemetery in Springfield in accord with an earlier request. Among the honorary pallbearers were Governor Oglesby, General Palmer, General McClernand, General Cook, General McConnell, Colonel Wickersham, Colonel Shelby Cullum, Colonel O. M. Hatch and other leading citizens.

About this time, he was nominated for U.S. Congress by the Republican party. This move in itself was quite a coup, because he had been a Democrat until this point in his career.

Upon her husband's death, Mrs. Lippincott was made matron of the home in Quincy, where she lived until her death in 1895. The Lippincotts' three sons, Linus, Winthrop and Thomas, all died before their parents.

There is a Lippincott building at the Soldiers and Sailor's Home in Quincy that was built by voluntary funds from friends in memory to General and Mrs. Charles E. Lippincott.

Conclusion

Lippincott was five feet ten

inches tall and solidly built. Photographs showed him to have sandy hair, blue eyes and heavy eyebrows. An adventuresome spirit provided the ambition he displayed from early adulthood. He was a good writer, storyteller and speaker.

In explaining why he had become a political turncoat, Lippincott argued that the Democratic party had gone astray. He was no friend of Abraham Lincoln, but gave full support to the administration—especially to the abolition of slavery. He was a man of honor, charity, benevolence and great dignity. He vacillated between adhering to conventional religion and certain unreligious principles. Evidently he was physically brave but may not have had moral courage. He belonged to the Masonic order and the Oddfellows.

A psychohistory scholar might have difficulty trying to explain Lippincott's many incompatible qualities. At school, he committed a number of misdemeanors. He was overly ambitious, to be sure. He killed a man in a duel and later testified that he had not been a participant. He left his admirable wife for several long periods. He changed political parties handily.

Few other members of the Illinois medical fraternity or in public life have experienced the vicissitudes of poverty and wealth, oblivion and fame, ostracism and heroism, defeats and successes as did Charles Ellet Lippincott. Surely, his varied and colorful life gained much from the stability, continuous support and genuine affection afforded him by his loving family, which remained loyal to him always. ◀

Acknowledgement

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References

A complete bibliography for "Charles E. Lippincott: A Country Doctor of Adventuresome Spirit" may be obtained by writing the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

A recent study found that depression occurs in over 50% of stroke patients and can be treated successfully with conventional antidepressants. Symptoms ranged from depressed mood, anxiety, restlessness, diurnal mood variations, hopelessness, loss of energy, sleep disturbances, self-deprecation, and suicidal thoughts. This is particularly prevalent in left hemisphere lesions with increased catecholamine depletion. Depression may last up to two years and its recognition falls upon the primary care physician. Treatment with tricyclic antidepressants may be tried. If therapy does not succeed within a six week period, these patients should be referred to a psychiatrist. (Robinson, R: *Hosp Pract* 21:4, 83-91, 1986)

Approximately one-third of the population over 100 years of age will succumb to Alzheimers disease. Such other factors as heredity, trisomy 21, and head trauma also appear to be significant. Loss of ascending transmitter cholinergic substances correlates well with loss in memory and function in life. The paired helical filaments of the neurofibrillary tangle and the amyloid at the core of the neuritic plaque suggest abnormal and unique fibrous proteins in the brains of persons with Alzheimers disease. (Katzman, R.: *N Engl J Med* 314: 15, 964-70, 1986)

Fibrositis, associated with muscle pain, is frequently given a psychiatric rather than a physical diagnosis. In this study, electrical charges on the contractile proteins were within normal limits but the microscopic examination showed a network of reticular or elastic fibers not seen in normal muscle tissue. These constricting bands of elastic fibers connecting muscle fibers during contraction elicited the pain associated with fibrositis. (Bartels, E., Danneskiold-Samsoe, B.: *The Lancet* 8484: 1,755-7, 1986)

Preoperative and admission chest x-rays have been performed routinely for years. These authors note that their value is questionable and that they should not replace a careful history and physical examination. The practice of routine chest radiographs should be restricted to those patients with clinical evidence of chest disease and those having intrathoracic surgery. (Tape, T., Mushlin, A: *Ann Int Med* 104: 5,663-70, 1986)

Antihypertensive therapy commenced with metoprolol 100mg once daily and was supplemented with hydrochlorothiazide 12.5mg when metoprolol alone was not satisfactory. This regimen was suggested in patients aged 60-75. Effects were noted in 4-8 weeks. Hypokalemia and hyperuricemia were reported in the hydrochlorothiazide treated group. (Wikstrand, J., *et al.: JAMA* 255:10, 1304-10, 1986).

A multicenter double blind study compared enalapril, atenolol, and hydrochlorothiazide for mild to moderate hypertension. The systolic and diastolic blood pressures were reduced in all three groups. Serum potassium was reduced and uric acid was elevated in the thiazide treated group, the fasting blood sugar was elevated in the atenolol group, and the systolic pressure was reduced to a greater degree in the enalapril group. Adverse reaction required withdrawal from enalapril in nine cases, 19 on atenolol, and eight on hydrochlorothiazides. (Helgeland, A. *et al: The Lancet* 8486: 1,876-80, 1986)

The true frequency of side effects from live measles-mumps-rubella vaccination was evaluated in a double blind study in 581 twin pairs. The most common adverse reaction was irritability on the tenth day in the vaccinated group, and the respiratory symptoms were more frequent in the placebo group. Fever above 39.5°C occurred during the 7-12 days in the vaccinated group in greater numbers than the placebo group. The authors suggest that some of the symptoms attributed to the vaccines may be concurrent common infections and that the vaccine may in fact give some transient protection against the common cold. (Peltola, H., Heinonen, O: *The Lancet* 8487: 1,939-42; 1986)

The incidence of bacteriuria in 1148 people of age 70+/- two months was evaluated. Mortality rates were recorded in this group for approximately nine years. The five-year mortality rate among women with bacteriuria was 13.4%; in those without bacteriuria it was 9.4%. The nine year mortality rate was 23.9 and 23.3 percent respectively. Men with bacteriuria had an increased incidence of cancer: 27.3% versus 5.8% at age 70. Among men with bacteriuria but without cancer the mortality rate was not different from those without bacteriuria. (Nordenstam, G. *et al: N Engl J Med* 314: 18,1152-6, 1986)

A significant amount of asymptomatic or silent myocardial ischemia occurs in individuals with effort angina. Silent ischemic attacks escape detection in these patients. It occurs 3-4 times as often as painful episodes, and may culminate in silent infarcts, sudden death, or other events. Ambulatory electrocardiographic monitoring provides the best long term evaluation of repeated episodes of silent myocardial ischemia. (Pepine, C.: *Am J Med* 80: 4C, 25-35, 1986). ◀

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

SEPTEMBER

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolaryngologists, DO's and DOV's. Laser workshop. September 29-30, Chicago, IL. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 25. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Nephrology/OB-Gyn/Family Medicine

Renal Function and Disease in Pregnancy
For: Nephrologists, obstetricians, and family practitioners. Symposium, September 18-20, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the National Kidney Foundation. **Fee:** $145. **Reg. Limit:** None. **Credit:** Category 1: 14 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Dermatology/Family Medicine/Geriatrics

National Symposium on the Prevention and Treatment of Pressure Ulcers
For: Dermatologists, family practitioners, and geriatrics specialists. Symposium, September 23-25, Chicago, IL. **Sponsors:** The University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637 and the Chicago Department of Health. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 12 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Internal Medicine/Family Practice

Office Treatment of Hypertension
For: Internists, family practitioners, cardiologists, and general practitioners. Conference, September 24, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 4 hours; AAFP Prescribed: 4 hours; and AOA: 4 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Psychiatry

Workshops for various specialties
For: Psychiatrists, anesthesiologists, family physicians, allergists, pediatricians. September 23-26, Chicago, IL. **Sponsors:** Society for Clinical and Experimental Hypnosis, 128-A Kings Park Drive, Liverpool, NY 13090; Department of Psychiatry and Department of Behavioral Sciences, University of Chicago; Department of Psychiatry, Michael Reese Hospital; Anesthesia Department, Northwestern University Medical School and Department of Psychology, University of Illinois at Chicago. **Fee:** $120-160 residents; $270-395 members; $340-480 non-members. **Credit:** Category 1: 30 hours; AAFP Elective: 30 hours; ADA: 30 hours; American Psychological Association: 30 hours. **Contact:** Marion Kenn. **Phone:** (315) 652-7299.

Critical Care/Medicine/Surgery

Fifth Annual Chicago Critical Care Symposium
For: Physicians and nurses. Lectures, tutorials, September 25-28, Chicago Marriott Hotel, Chicago, IL. **Sponsor:** University of Health Sciences/The Chicago Medical School, c/o Liz Bruechert, CME Office, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $360 for physicians, $220 for nurses. **Reg. Limit:** None. **Credit:** Category 1: 24 hours; AAFP Prescribed: 24 hours; AACN: 24 hours; and ACEP: 24 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Emergency Medicine

6th Annual Current Emergency Care Problems Conference
For: Physicians. Conference, September 11-12, Madison, WI. **Sponsor:** University of Wisconsin-Madison, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Emergency Medical Services Program, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; AOA Category 2-D: 11.5 hours; and Univ. of Wisconsin CEUs: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Ophthamology/Neurology

Second University of Wisconsin Clinical Neuro-Ophthamology Symposium
For: Ophthamologists and neurologists. Symposium, September 5-6, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Departments of Ophthamology and Neurology, School of Medicine. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Neonatology

Perinatal Care: Current Issues for the Primary Care Provider
For: Family physicians, obstetricians, general practitioners, and pediatricians in east central Illinois. Conference, September 13, Jumer's Castle Lodge, Urbana, IL. **Sponsor:** Carle Foundation Hospital, 611 W. Park Street, Urbana, IL 61801; Carle Clinic Association and University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $100. **Reg. Limit:** None. **Reg. Deadline:** September 5, 1986. **Credit:** Category 1: 6.5 hours; AAFP: 6.5 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3108.

Dermatology

Specialty Review in Dermatology
For: Dermatologists. Lecture, September 15-19, Chicago, IL.. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 42 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Obstetrics and Gynecology

Specialty Review in Obstetrics and Gynecology: A Practical Aspect
For: Obstetricians and gynecologists. Lecture, September 15-20, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $715. **Reg. Limit:** None. **Credit:** Category 1: 55 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Neurology

Current Clinical Neurology: A Comprehensive View
For: Neurologists, psychiatrists and neurosurgeons. Lecture, September 22-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $570. **Reg. Limit:** 55. **Credit:** Category 1: 42 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Cardiology/Family Medicine/Radiology/Surgery

The Eleventh Annual Nuclear Cardiology Symposium
For: Physicians and other health professionals. Symposium, Septemher 25-26, Milwaukee, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, University of Wisconsin School of Medicine, Mt. Sinai Medical Center, and The American Heart Association. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 18 hours, University of Wisconsin CEUs: 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Neurology/Family Practice/Internal Medicine

4th Annual Neurology Conference: Diagnosis and Treatment of Pain
For: Physicians. Conference, September 26-27, Madison, WI. **Sponsors:** University of Wisconsin-Madison-CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Department of Neurology, School of Medicine, University of Wisconsin. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed: 9.75 hours; AOA Category 2-D: 9.75 hours; University of Wisconsin CEUs: 20 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Occupational Medicine

New and Emerging Topics for the Occupational Practitioner
For: Physicians and other health professionals. Seminar, September 26-27, Mayo Clinic. **Sponsor:** Central States & North Central Occupational Medical Associations, 2010 Lexington Drive, Palatine, IL 60074. **Fee:** $95 for physicians and $65 for all others. **Reg. Limit:** None. **Credit:** Category 1 applied for. **Contact:** Marlyce Nutt. **Phone:** (312) 991-5016.

Internal Medicine

Specialty Review in Infectious Disease
For: Internists and infectious disease specialists. Lecture, September 22-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Specialty Review in Nephrology
For: Nephrologists and internists. Lecture, September 22-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Specialty Review in Rheumatology
For: Internists and rheumatologists. Lecture, September 28-October 2, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Specialty Review in Pulmonary Disease
For: Pulmonologists and internists. Lecture, September 28-October 2, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** The Registrar. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

October

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, October 31-November 2, Chica-

go, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Ob/Gyn/Geriatrics/Pediatrics/Urology

Medical Seminar-at-Sea (Mediterannean/Holy Land Cruise)
For: Physicians. October 19-November 1. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine

17th Family Medicine Review
For: Family physicians. Course, October 26-31. **Sponsor:** University of Kentucky College of Medicine, Office of CME, 132 COM Office Building, Lexington, KY 40536. **Fee:** $425 ($450 after 10/10). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP: 50 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Neurology

Clinical Neuroimmunology IV: Demyelinating Diseases and AIDS
For: Neurologists. Course, October 23-25. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Surgery

The Chicago Temporal Bone Surgical Dissection
For: Otolaryngologists. Course, October 6-10, Hinsdale Hospital, Hinsdale, IL. **Sponsor:** Dept. of Otolaryngology, Northwestern, Loyola University and Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521. **Fee:** $900-physicians; $600-residents. **Reg. Limit:** 8. **Credit:** Category 1: 40 hours. **Contact:** Cherie Jones, MPH. **Phone:** (312) 887-2400.

A Curative Approach to Sarcomas
For: Oncologists, pathologists, orthopaedic surgeons and radiation therapists. Course, October 17-18, Nordic Hills Resort, Itasca, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $75. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Elective: 7 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine/Internal Medicine

Comprehensive Care of the Diabetic Patient: An Update
For: Internists, family practitioners, and endocrinologists. Course, October 11, 9:00 a.m.-1:00 p.m., Highland, IN. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $30. **Reg. Limit:** None. **Credit:** Category 1: 3 hours; AAFP Elective: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Obstetrics/Gynecology

Perinatal Medicine-Back to the Basics
For: Perinatalogists, neonatalogists, and obstetricians. Symposium, October 16-17, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 13 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiology

Echocardiography 1986
For: Cardiologists and echocardiographers. Course and workshop, October 21-24, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $350. **Registration Limit:** 250. **Credit:** Category 1: 26 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolaryngologists. Laser Workshop, October 27-28, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Pentenney. **Phone:** (312) 908-8533.

Ear, Nose, and Throat Practicum
For: Physicians. Conference, October 9-10, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 17.25 hours; AAFP Prescribed: 17.0 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Surgery

Hemodynamic Monitoring
For: Physicians. Conference, October 2-3, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 10 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Pediatrics

Perinatology/Neonatology 1986: Compromised Fetus, Perinatal Problems, High-tech Neonatology
For: Neonatologists and pediatricians. Conference, October 16-17, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 13.25 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Occupational Medicine/Family Medicine

Impairment Evaluation & Disability Considerations: Medical & Legal Perspectives.
For: Physicians. Conference, October 27-29, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 15.5 hours; AAFP Prescribed: 15.5 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Allergy/Immunology

Update in Allergy and Clinical Immunology III-1986
For: Physicians and other health professionals. Conference, October 2-3, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Department of Medicine, School of Medicine, University of Wisconsin-Madison, and University of Wisconsin Hospital and Clinics. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA Category 2-D: 13 hours; and Univ. of Wisconsin CEUs: 13 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Neurology/Surgery/Radiology

Neuroradiology 1986
For: Physicians and other professionals. Conference, October 17-18, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Department of Radiology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, University of Wisconsin CEUs: 10 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Urology/Surgery

Surgical Treatment of Urinary Incontinence
For: Physicians. Conference, October 23-24, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Departments of Surgery and Obstetrics and Gynecology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 15 hours, University of Wisconsin CEUs: 15 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pediatric Rheumatology

Update: Pediatric Rheumatology
For: Rheumatologists and pediatricians. Seminar, October 30, Chicago, IL. **Sponsor:** LaRabida Children's Hospital and Research Center, East 65th St. at Lake Michigan, Chicago, IL 60649. **Fee:** $60. **Reg. Limit:** None. **Reg. Deadline:** October 22. **Credit:** Category 1: 7 hours. **Contact:** Helen Emery, M.D. **Phone:** (312) 363-6700 X520.

NOVEMBER

Allergy

Clinical Allergy For the Practicing Physician
For: Physicians. Seminar, November 6-8, St. Louis. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $175. **Reg. Limit:** 150. **Credit:** Category 1: 19.25 hours; AAFP Prescribed: 19 hours; AOA: 19.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Anesthesia

Workshop in Fiberoptic Endoscopy
For: Anesthesiologists. Lecture, November 8, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $225. **Reg. Limit:** 50. **Credit:** Category 1: 7 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiac Rehabilitation

For: Physicians and other health professionals. November 10-14, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and the Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Geriatric Medicine

43rd Annual Scientific Meeting of American Geriatrics Society and 7th Annual Meeting of American Federation for Aging Research
For: Physicians. Convention, November 16-19, Chicago, IL. **Sponsors:** American Geriatric Society, 10 Columbus Circle, Rm. 1470, New York, NY 10019; American Federation for Aging Research. **Fee:** $125 (members), $150 (non-members). **Reg. Limit:** None. **Credit:** Category 1: 27 hours; AAFP Prescribed: 27 hours. **Contact:** Barbara Popecki. **Phone:** (212) 582-1333.

Neurosurgery

Neurosurgery Laser Workshop
For: Neurosurgeons. Workshop, November 17-18, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Registration Limit:** 12. **Credit:** Category 1: 19 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Obstetrics/Gynecology

Hysteroscopy Workshop
For: Gynecologists. Conference and workshop, November 14-15, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $325. **Reg. Limit:** 150. **Credit:** Category 1: 11.5 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Obstetrics/Gynecology/Family Medicine/Pediatrics

New Technologies in Clinical Genetics
For: Ob/Gyn's, pediatricians and family practitioners. Lecture, November 15, Holiday Inn-Alsip, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $35. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Elective: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine

Child Abuse
For: Physicians. Conference, November 3-5, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 18 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Surgery

Ins & Outs of Critical Care
For: Physicians. Conference, November 11-12, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 12 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Continuous Monitoring by Venous Oximetry
For: Physicians and allied health professionals. Conference, November 14. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6.25 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Michigan Society of Critical Care Medicine
For: Physicians. Conference, November 15, Ann Arbor, MI. **Sponsor:** Michigan Society of Critical Care Medicine, Townsley Center, Box 0201, Ann Arbor, MI 48109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

New Officers Installed

By Robin Bluestein, CMA-C

The 1986-87 officers of the Illinois Society of Medical Assistants (ISMA) were installed on Saturday April 26, at the Hyatt Regency Hotel in Schaumburg.

Mary Lu Ostrowski, CMA, was installed as president. Mrs. Ostrowski is a member of the McLean County Chapter. She has been in the field of medical assisting for 23 years and has been a member of the organization for 17 years.

Mrs. Ostrowski has stated that her goals for 1986-87 are to (1) increase membership; (2) make the physician more aware of the advantages of certification; (3) continue to upgrade the Illini Cardinal (the state publication); (4) involve the entire membership and (5) maintain ISMA as a viable organization, focused on the future and making optimal use of the resources of experienced members.

Cheryl Hutchison, CMA, a member of the St. Clair County Chapter, was installed as president-elect. Mrs. Hutchison, a medical assistant for 17 years and a member of the organization for 10 years, will help the president this year, particularly in efforts to increase membership.

Catherine M. Hill, CMA, a member of the West Cook County Chapter, was installed as 1st vice president. Ms. Hill hopes to increase membership and physician awareness. She will seek to reach a wider variety of physicians through *Illinois Medical Journal* articles and to increase student awareness by speaking to the various medical assisting schools.

Rebecca R. Matteson, CMA, EMT, a member of the Spoon River Valley County Chapter, was installed as 2nd vice president. Marjorie Goldasich, a member of the LaSalle County Chapter, was installed as recording secretary. Linda Harp, CMA, a member of the St. Clair County Chapter, was installed as membership secretary.

Mary Frances Burton, a member of the Chicago Chapter, was installed as treasurer. Mrs. Burton has been a medical assistant for 25 years and a member of the organization for 13 years. She hopes to establish policies to ensure that future treasurers will communicate effectively throughout the year and will encourage increased funding for educational functions and lower charges for member attendance.

Bernyce Carberry, a member of the McLean County Chapter, was installed as corresponding secretary. A. Ruth Thompson, CMA, a member of the Macon County Chapter, was installed as vice speaker of the house. Betty Kronemeyer, CMA, a member of the St. Clair County Chapter, was installed as speaker of the house.

Ehlma Garcia, CMA, EMT-A, was appointed immediate past president for the coming year. Other appointed officers include Julie Stoffregen, CMA, historian and Darlene Van Dyke, chaplain.

New Name Instituted

As voted in the House of Delegates, this society is the Illinois Society of Medical Assistants, Inc. (An Affiliate of the American Association of Medical Assistants, Inc.). Therefore, in the future, the abbreviation ISMA (Illinois Society of Medical Assistants) should be used instead of AAMA (American Association of Medical Assistants).

Annual Meeting Scheduled

The AAMA Annual Meeting will be held October 17-19, 1986 in Chicago, Illinois. As stated in a previous article, only the business portion will be conducted. Regional conferences with educational programs and social activities are to be held throughout the United States. A future article will feature the results of the annual meeting in October.

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 East Jackson Street, Bloomington, IL 61701; Robin Bluestein, CMA-C, co-chairman, public relations committee, 2247 West Estes Ave., Chicago, IL 60645 or Catherine M. Hill, CMA, co-chairman, public relations committee, 900 South Plum Grove Road, Palatine, IL 60067. ◀

CLASSIFIED ADVERTISING

Classified Advertising Rates

	25 words or less	26 to 50 words	51 to 75 words	76 to 100 words
1 insertion	$ 7.00	$17.00	$25.00	$ 42.00
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6 insertions	18.00	44.00	64.00	108.00
12 insertions	22.00	53.00	79.00	132.00

All proposed advertisements should be received by the first of the month preceding publication. A surcharge of $5 will be assessed when a box number is requested.

POSITIONS AND PRACTICE

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Allison Katz, Staffing Specialist. National Emergency Services, Inc., 255 Executive Drive, Suite 104, Plainview, NY 11803 or call (800) 645-4848 or (516) 349-0100.

ARIZONA BASED Physician recruitment firm has opportunities coast to coast. "Professionals working with Professionals." Over 14 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PRACTICE/Internal Medicine—Central Illinois. Various opportunities available: solo and group. Reply to Box 1186, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CARDIOLOGY: 56-MD multispecialty group seeking second cardiologist to associate in an excellent growing consultative practice, combining both invasive and non-invasive opportunities. Well-equipped offices in a modern, accredited facility. Drawing area nearly 400,000 with two well-staffed, modern hospitals. Stimulating midwest, Big-10 university community of 100,000 with superb cultural advantages. Ideal for family. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship and subsequent income based exclusively on productivity. Send C.V. to Box #2004, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WELL ESTABLISHED PRACTICE for sale. General practice and general surgery. Chicago suburb. Will introduce up to one year. Grossing over $200,000. Reply to Box #2006, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SURGEON: Looking for associate in the established practice of general surgery. Suburb of Chicago. Reply to Box #2007, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PRIMARY CARE PHYSICIAN for Northbrook clinic. Full or part time. An exciting opportunity to have your own practice with no overhead or start-up expenses. Send C.V. to Medical Director, 1186 Northbrook Court, Northbrook, IL 60062.

IMMEDIATELY NEEDED: Family practice/internist. Guaranteed $35/ hour plus percentage. Close to St. Louis. Hospital privileges: community and St. Louis. Call (618) 254-7478.

PHYSICIANS NEEDED for opportunities in Arizona. Send C.V. to: Fred Wellhausen, Western Personnel, 316 E. Flower, Phoenix, AZ 85012.

INDUSTRIAL CLINIC needs physician part-time weekdays in southwest suburb. Need Illinois license and your own malpractice. Send resume and hours available to: Southwest Industrial Care, 7600 W 119th St, Palos Heights, IL 60463.

WANTED: ILLINOIS licensed physicians to perform life insurance histories and physicals. Also ECG. (312) 763-8744.

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FAMILY PRACTICE—Immediate need for two B/C family practitioners for opportunity in Phoenix, AZ. For more details, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

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FAMILY PHYSICIAN AND PEDIATRICIAN—Michigan City, Indiana, 50 miles southeast of Chicago. Thirty-physician multispecialty group. Two fully accredited acute care hospitals with over 300 total beds. Modern, fully equipped clinic. Michigan City has a population of 60,000 with over 100,000 drawing area. Competitive salary, full benefits. Located on Lake Michigan. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice, pediatrics and OB-GYN. Positions include income guarantee and no capital investment. For more information, contact Barry Trautman, 8401 Hanley Industrial Ct., St. Louis, MO 63144, (314) 962-1233.

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WANTED—E.R. Physicians—STAT,P.C., a professional corporation providing St. Joseph Mercy Hospital emergency department physician services, looking for qualified part-time or full-time physicians to staff the emergency department. Please direct inquiries to Lambert C. Orton, M.D., STAT,P.C., 84 Beaumont Drive, Mason City, IA 50401. (515) 424-STAT(7828).

SITUATIONS WANTED

INTERNIST SEEKS part or full time position: days, evenings, or nights Chicago metropolitan area. Experienced in occupational/ industrial and general practice. University trained. Reply to Box #1198, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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FOR SALE, LEASE OR RENT

USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, ultrasound diathermy, surgical instruments, microscopes, etc. Please call or write Robert Shapiro at 512 Warren Road, Glenview, IL 60025; (312) 743-3900.

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PRACTICE FOR SALE. Well-settled moderately busy, eight-year old pediatric practice located in northwest side of Chicago. Low rent and overhead. Terms negotiable. Call (312) 973-7362 evenings.

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WOULD YOU LIKE to make your patients feel more comfortable? Decorate your office with customized artwork and accessories. For free consultation, call Rena Designs (312) 965-6963.

EKG

(Continued from page 54)

Answers: 1. A, C 2. B

The twelve lead ECG shows a wide QRS rhythm at a rate of 70 beats per minute. There is no consistent relationship between the P waves and the QRS complexes. P waves are marked in leads III and AVF, but the rate of the sinus is 115 beats per minute. A second P wave is buried in the QRS waves except for lead V1. The last beat in lead V1 is the only sinus capture beat in the tracing, and it has the configuration of complete left bundle branch block. This is AV dissociation with sinus tachycardia caused by severe or high grade AV block. Only one sinus capture beat was seen. The wide QRS suggests a ventricular pacemaker, but it is faster than usual ventricular rates and much slower than usual ventricular tachycardia rates. This is an accelerated idioventricular rhythm. The patient received an A-V sequential pacemaker (DDD) that followed his sinus rate.

Conduction system disease in patients with aortic stenosis has been well described. The bundle of His and the His-Purkinje system are more often involved than the sinus or AV nodes. The severity of the aortic valve obstruction correlates with the disease in the trifascicular system. There is also a correlation between the severity of conduction system disease and the severity of aortic valve calcifications.[1]

Our patient developed complete right bundle branch block after his second aortic valve surgery. Now he shows left bundle branch block on one sinus conducted beat. This would support the concept that his AV block is caused by His bundle or trifascicular conduction system disease. Latent damage to the His-Purkinje system could be caused by calcific aortic stenosis and then worsened by aortic valve replacement surgery. With the A-V sequential pacemaker in place, our patient improved and no further work-up was necessary. ◀

Reference

1. Dhingra, R.: "Sites of Conduction System Disease in Aortic Stenosis," *Annals Int Med* 87:275-280, 1977.

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It's Time to Finish the Job



During the last couple of months, some good and some bad has occurred in our efforts for tort reform.

The Illinois State Supreme Court found four of the five challenged elements of last year's malpractice reform legislation to be constitutional. That was good. On the other hand, they felt that the pre-trial screening panels section was unconstitutional as written. That was bad.

I think we can feel satisfied that most of our effort last year was not in vain. Also, while we awaited the Supreme Court decision, a coalition of groups which have now felt the impact of the increasing liability crisis generated activity in Springfield on tort reform. Unfortunately, the bills that came out of the legislature were weak and will have little to no effect on the crisis. That was also bad.

But we have learned a lesson from this. The lesson is that no one will do it for us. If there is to be any further meaningful reform it will have to be initiated by our own Society with the backing and wholehearted support of all its members. Last year we proved that we could be a force in dealing with our political leaders. We did this with the backing of our whole membership, but not the active support of all our members. Just think what we might be able to do if all our members became involved in contacting our legislators and educating the public through our patients and friends. Your ISMS leadership and staff will do the heavy work, but without a strong grassroots push, it won't mean very much.

On the second weekend in November we will be having our annual All Member Conference at the Drake-Oakbrook. I would hope that, at the very least, we will see one representative from every hospital medical staff in Illinois at this important event. This will be the kickoff for a Professional Liability Initiative to bring us caps on non-economic damages and a reasonable statute of limitations for minors.

This month's *IMJ* features a number of articles on issues slated for discussion at the November All-Member Conference. An interview with ISMS legislative strategist Saul Morse is a solid primer on malpractice reform activity to date. Stories on the legislative battle for limits on non-economic damages and possible surprises to expect in conjunction with "sunset" review of the Medical Practice Act should be of interest to every Illinois physician. All three should stimulate your interest in this year's All-Member Conference.

Members who attend will be instructed and given the tools to launch a major grassroots campaign. Let's pretend that we will be alone in our quest again, so that we can be stronger than before and finish the job this time. ◂

Jere E. Freidheim, M.D.
President

THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Nancy Budorick, M.D., Department of Radiology, Loyola University Medical Center, Maywood.



Figure 1

This 36-year-old woman has had three bouts of pneumonia in the past two months. She now has acute fever and cough. She has had recurrent oral and vaginal candidiasis for one year. Blood transfusions had been given five years earlier when she was post-partum.

What is your diagnosis?

(1) *Pneumocystis carinii*
(2) Allergic alveolitis
(3) Alveolar cell carcinoma
(4) Acquired immunodeficiency syndrome

(continued on page 163)



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C I B A

AMA Confronts Medical Staff Issues

The AMA Annual Meeting in June provided exciting opportunities for medical staff section input this year. The ISMS HMSS delegation was the largest in the AMA HMSS. A total of 69 Illinois medical staffs were represented.

Commenting on the number of physicians present, HMSS Chairman Raymond A. Dieter, Jr., M.D., said: "Although we can be proud of our showing, we did not have representation from all medical staffs in Illinois. We need to get the word out that this Section is accomplishing some things for medicine, and could do even more if we had greater participation".

Several important issues were debated at the recent AMA HMSS meeting in Chicago. Two of the most important were:

- Report AA from the AMA Board of Trustees, which was heartily supported by medical staff leaders. The report expounds on the legal status of the medical staff, and argues forcefully for self-governance. It also alludes to the contractual relationship, formed by the medical staff bylaws, between the medical staff and governing body.
- The composition of the medical executive committee should be determined by the medical staff, not the governing body, according to the AMA HMSS. The AMA House of Delegates agreed, and has instructed the JCAH commissioners from AMA to seek appropriate revision of the JCAH standards. Thomas C. Malvar, M.D., HMSS representative for St. Mary of Nazareth Hospital, introduced this subject into the AMA HMSS.

The next meeting of the ISMS HMSS will be in Las Vegas, December 5-6, 1986 in conjunction with the Interim AMA HMSS meeting. Medical staffs seeking information on the Section should contact ISMS at 312/782-1654. ◀

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SPECIAL ARTICLE

ISMS Public Service Awards

Do you know someone who contributes that extra measure of time and talent to better your community and serve its health care needs? Do you know someone whose unrelenting energy, enthusiasm and altruism catalyze others to community action and education? Do you know someone whose leadership in helping others truly stands out? If so, you know someone who should be nominated to receive an ISMS Public Service Award.

The ISMS Public Service Awards were established by the ISMS Board of Trustees in June, 1986, to recognize outstanding community outreach, education and other public service efforts in the health care field. Nominees compete in two annual award categories—physician and non-physician.

Members who know of a colleague or someone in the community who meets the qualifications outlined below, are asked to bring that person to the attention of their local county medical society or state specialty society. Nominations are due October 15. For more information or nomination forms, please contact the ISMS public relations staff at 312-782-1654 or 1-800-782-ISMS.

Purpose

The Illinois State Medical Society will annually receive nominations to honor both an Illinois physician and a non-physician for outstanding public service and community outreach efforts on health care issues. The award is *not* designed as a "popularity contest" but rather an avenue for recognition of real, valued contributions to public education on Illinois health care issues.

Criteria

Each physician nominee must be an ISMS member who spends at least 50% of his or her time in direct patient care. He or she must have been in practice for five years, and be an active participant in *non-reimbursed* public service and community outreach activities on health care issues.

Non-Physician Nominees (e.g., community leaders and groups, not-for-profit organizations, news reporters, citizens) must be active participants and leaders in communicating health care issues to Illinois patients through news media, community affairs or specific public service projects. They should be persons who have worked to promote broad, balanced public education on the patient's role in health maintenance and shown themselves to be active advocates on Illinois community health care issues for two years. Nominees must be Illinois residents conducting these activities within the state. Consulting or public relations firms are ineligible; nominees must be principals in community outreach efforts.

Nominations

Component medical societies (including county medical and recognized state specialty societies) of the Illinois State Medical Society shall be entitled to nominate one candidate in each category annually. Outside nominations will also be considered for the non-physician award. Nominations must be submitted to the ISMS Council on Public Relations and Membership Services by October 15, 1986.

Selection Process

The ISMS Council on Public Relations and Membership Services will review nominees and select the final candidate in each category for ratification by the ISMS Board of Trustees.

Annual awards are not mandated; the Council will recommend awards in each category only if and when candidates and their public service/community outreach efforts merit recognition.

Award Presentation

Suitable awards shall be presented to the physician and non-physician winners at the ISMS annual House of Delegates meeting.

Limitations

Members of the ISMS Board of Trustees, ISMIS Board of Directors, ISMIE Board of Governors and ISMS Council on Public Relations and Membership Services are not eligible to receive the physician award during their terms of service or for five years thereafter.

Supporting Documentation

A personal nominating letter must come from the county medical or specialty society president explaining the reasons for a candidate's nomination. It shall be accompanied by the completed nomination form and a current CV (or biographical information) on the candidate. Also attached, if available, should be a few samples of pertinent materials relating to the candidate's public service/outreach efforts. Individuals may be nominated more than once; if a nomination is unsuccessful in one year, a second nomination may be considered in the following year.

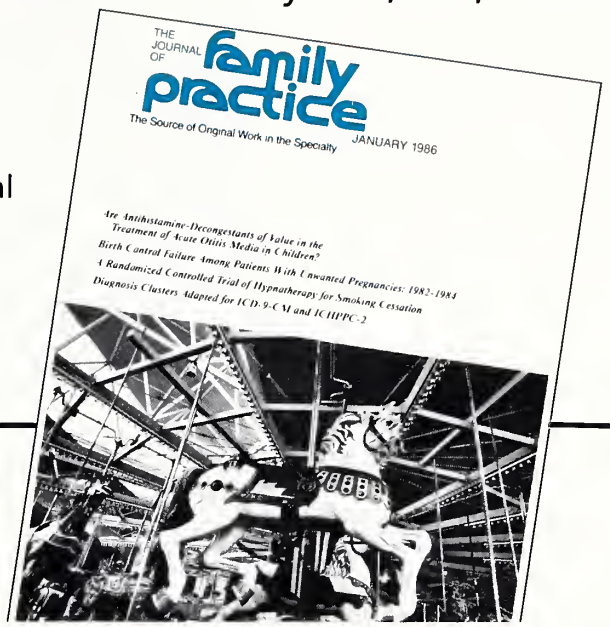
Additional information is available through the ISMS public relations staff at 1-800-782-ISMS. ◀

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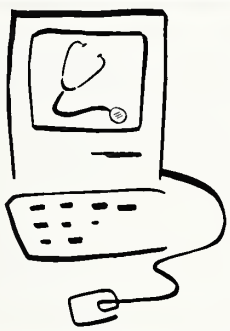
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ISMS All-Member Conference
November 8, 1986

Restoring the Balance

The ISMS All-Member Conference will be held Saturday, November 8, at the Drake-Oakbrook Hotel. It promises to be a stimulating, fast-paced day of seminars and debate. Physicians and spouses who attend will leave with a firm grasp of legislative strategy for 1987, as ISMS maps the path to crucial malpractice reforms.

Registrants for the ISMS All-Member Conference should plan to arrive at the Drake-Oakbrook hotel by 6:00 on Friday evening, November 7, for a "get acquainted" cocktail reception.

The ISMIE Network will meet for breakfast on Saturday, November 8 at 8:00. All conference participants are invited. The new ISMIE claims-made product will be the main topic for discussion, but the breakfast provides a forum for all questions and concerns.

The formal program begins at 9:00 a.m., when Cook County Circuit Court Judge Edwin Berman will give the opening address with his perspective on the impact of the Illinois Supreme Court rulings on the 1985 malpractice reform legislation.

Morning presentations will include key legislators' predictions on how the November elections will influence the outcome of proposals of interest to medicine. Special focus will be given to legislative arguments for and against caps on non-economic damages. Speakers will also include experts in physician contracting issues.

The luncheon speaker, F. Lee Bailey, will talk about the image of the judicial system in America today. Mr. Bailey is a colorful, articulate defense attorney with extensive litigation experience.

Afternoon sessions will cover expected developments as the General Assembly considers the Medical Practice Act under "sunset" review this session. A special seminar on media relations will highlight skills & strategies in working with members of the media in community education on public policy issues. Registrants will also have an opportunity to meet with other physicians from their legislative districts to discuss grassroots strategy for malpractice reform over the coming months.

The conference will close with a salute to Attorney General Neil Hartigan, who successfully defended the constitutionality of the 1985 medical malpractice legislation.

Conference registration of $50 for ISMS and ISMSA members will cover all materials and refreshments. Members and their spouses will receive further information by mail in the coming weeks. ◀

RESTORING THE BALANCE



Illinois State Medical Society
All-Member Conference
Saturday, November 8, 1986
The Drake-Oakbrook

The ISMS All-Member Conference will provide the knowledge and skills to bring about critical changes in malpractice law this year. Registrants will get the facts they need to persuade legislators and members of the media to support caps on non-economic awards and a revised statute of limitations for minors. A multi-faceted program for the physician as citizen and community leader will encompass:

- A post-election report on the new General Assembly and predictions on its response to legislative initiatives
- Legislative district round-tables to map out grassroots strategy for the 1987 initiative
- Professional media opinion as to how interest groups can influence public policy
- Legislative and allied health professional impact during "sunset" review of the Medical Practice Act
- The new contract review service offered by ISMS at no cost to its members

F. Lee Bailey, one of the nation's foremost defense lawyers, will be the luncheon speaker. He will address the court system in America from the perspective of an experienced litigation attorney.

Physicians and spouses will learn what they need to know as effective citizens and community leaders:

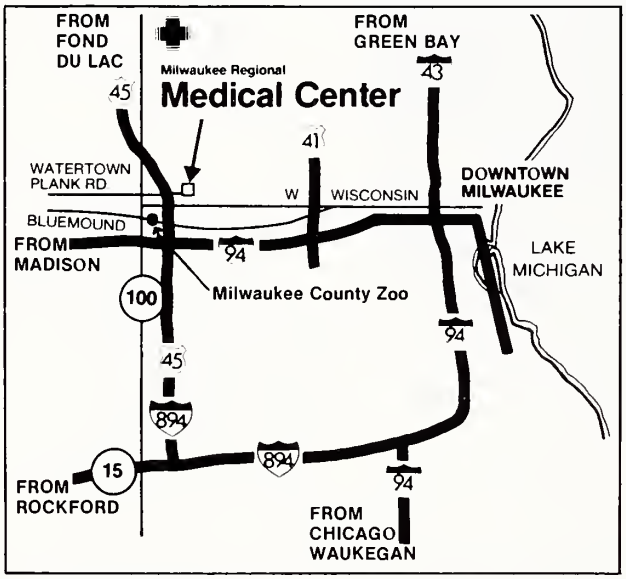
- *How* legislators view caps on non-economic awards in malpractice cases
- *Who* may try to amend the Medical Practice Act and which changes may endanger the integrity of the profession
- *Where* the medical community is most needed in the 1987 battle for malpractice reform
- *What* results can be expected from efforts to pass caps on awards and a revised statute of limitations for minors
- *When* efforts to influence legislators, the public and the media are most effective

Registration materials will be sent to all ISMS and Auxiliary members. Additional information is available from ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. The Society may be contacted by telephone also: (312-782-1654; 1-800-782-ISMS).

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Unitec, Inc.	800-237-3762 ext 284
Univair, Inc. (UNI-CLAIM)	314-426-1099
Westland Software House, Inc.	800-423-5880

New vendors, billing services and carriers added regularly. For up-to-date list, call 800-433-3683, ext. 7321.

OBITUARIES

Cohen, Edward, Elgin, died July 12, 1986 at the age of 51. Dr. Cohen was a 1965 graduate of the University of Health Sciences/Chicago Medical School.

***Epperson, Eugene B.,** Mount Vernon, died January 9, 1986 at the age of 65. Dr. Epperson was a 1944 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

****Giltner, O.B.,** Sheffield, died June 29, 1986 at the age of 83. Dr. Giltner was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

****Guerrieri, John A.,** Buffalo Grove, died July 19, 1986 at the age of 75. Dr. Guerrieri was a 1935 graduate of the University of Health Sciences/Chicago Medical School.

***Helal, Abdel H.,** Chicago, died April 10, 1986 at the age of 52. Dr. Helal was a 1957 graduate of Kasel-Aini-Faculty Medicine Cairo University, Cairo, United Arab Republic.

****Hubble, William F.,** Decatur, died July 5, 1986 at the age of 76. Dr. Hubble was a 1936 graduate of the University of Louisville School of Medicine, Louisville, Kentucky.

****Hurwitz, Paul,** Skokie, died July 18, 1986 at the age of 78. Dr. Hurwitz was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

Kopcha, Joseph E., Gary, Indiana, died July 29, 1986 at the age of 80. Dr. Kopcha was a graduate of Rush Medical College, Chicago.

****Menendian, Rose V.,** Park Ridge, died July 20, 1986 at the age of 86. Dr. Menendian was a 1927 graduate of the University of Health Sciences/Chicago Medical School.

***Mercer, Thomas H.,** River Forest, died July 2, 1986 at the age of 68. Dr. Mercer was a 1944 graduate of Northwestern University Medical School, Chicago.

****Michel, William J.,** Laguna Hills, California, died in June, 1986 at the age of 90. Dr. Michel was a 1921 graduate of Northwestern University Medical School, Chicago.

***Neuhoff, Carl F.,** Peoria, died July 13, 1986 at the age of 73. Dr. Neuhoff was a 1938 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

****Stuppy, George W.,** Chicago, died July 31, 1986 at the age of 88. Dr. Stuppy was a 1932 graduate of the University of Chicago Pritzker School of Medicine.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Philip G. Thomsen, M.D., ISMS Past President

Philip G. Thomsen, M.D., an ISMS past president, died April 1, 1986 at the age of 75.

A 1935 graduate of the University of Illinois College of Medicine, Dr. Thomsen served the Society in many roles. He was the Society's 1968-69 president, and also served several years as a member of the Board of Trustees. Dr. Thomsen served as Chairman of IMPAC, the ISMS Finance Committee and the Committee on Usual and Customary Fees. He was a member of the Legislation and Public Affairs Committee and the Liaison Committee with Medical School Deans.

Dr. Thomsen was active in medicine on the national level as well. In 1976, he was one of the three members of the U.S. Delegation to the World Health Organization's annual meeting in Geneva. He also served as a member of the Policy Committee for the U.S. Chamber of Commerce.

Dr. Thomsen held several state appointments also, including chairmanship of the State of Illinois Department of Registration and Education Medical Examining Board, and membership on the Cook County Hospital Governing Commission.

A native of Dolton, Dr. Thomsen served as president and also treasurer of the South Cook County Branch, Chicago Medical Society. He was president of the St. Francis Hospital Medical Staff in Blue Island for three terms. Upon retirement, Dr. Thomsen relocated to Albuquerque, New Mexico.

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This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

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Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

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The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

Vote on Tuesday, November 4, 1986!

November Elections Crucial to Further Tort Reform

Illinois physicians have an opportunity to make a difference when they vote for state and national offices this November. It's not too soon to verify that registration is valid at the current address or arrangements have been made to vote absentee (see box). The candidates elected on November 4 will be the people who decide the fate of malpractice reform legislation this spring.

The nation's eyes will be on Illinois on Tuesday, November 4, to see how Illinois voters will cast their ballots with Lyndon LaRouche candidates listed as Democrats, while Democrats bear the name "Solidarity." At the top of the ticket, Democratic incumbent Alan Dixon will face Republican challenger State Representative Judy Koehler. GOP Governor James R. Thompson, who signed the 1985 medical malpractice reform legislation and who lobbied for physician contracting, will have a rematch with Adlai E. Stevenson. Stevenson will be listed not under the traditional Democratic Party, but under the third party name of "Solidarity" (although the use of the name Solidarity may be challenged). Lt. Governor candidates are incumbent Republican George Ryan, Democrat (LaRouche) challenger Mark Fairchild and Solidarity candidate Michael Howlett, Jr. Incumbent Attorney General Neil Hartigan, who successfully defended the constitutional challenge of the 1985 medical malpractice reform laws, is facing Bernard Carey, appointed to the Attorney General slot after primary winner James Ryan, mayor of Arlington Heights, was forced to abandon the race.

In the Secretary of State's race, incumbent GOP Secretary of State James Edgar is being challenged by Democrat (LaRouche) candidate Janice Hart and Solidarity candidate, Jane Spirgel. Comptroller Roland Burris is being challenged by Republican State Senator Adeline Geo-Karis, who will continue to serve in the Senate if she is not elected. Incumbent Treasurer James Donnewald was defeated in the primary by former treasurer Jerry Cosentino, who will face GOP candidate, Mike Houston, the mayor of Springfield.

U.S. House

In the state's 22 congressional races, vacancies in the fourth and 14th Districts will add at least two new faces to the Illinois delegation to Washington. The death of Congressman George O'Brien places Assistant Republican Leader State Representative Jack Davis (R-Will) against Democrat Shawn Collins in the fourth district. There has been speculation that Collins has been asked to step down so that George Sangmeister (D-Will), the State Senator defeated as the Democratic candidate for Lt. Governor, could run. In the 14th District, freshman incumbent John Grotberg dropped out of the race due to illness. The GOP nominee is State Representative Dennis Hastert (R-Kendall), who has served as Republican spokesman on the important Appropriations II Committee. His opponent is Kane County Coroner Mary Lou Kearns. Herb Sohn, M.D., (R-Cook) is in a rematch with Democratic incumbent Congressman Sid Yates in the 9th District, while freshman GOP incumbent Harris Fawell is facing a challenge from Dominick Jeffrey. In the 17th District incumbent Democratic Congressman Lane Evans faces Sam McHard, a health care attorney and farmer. In the 20th District, incumbent Congressman Richard Durbin will face GOP nominee Kevin McCarthy, while in the 21st and 22nd Districts, Democrat incumbent Mel Price and GOP incumbent Ken Gray face strong challenges from Bob Gaffner and Randy Patchett.

State Senate

The Senate now holds 31 Democrats and 28 Republicans. Both parties have designated their own target races, the Democrats to hold control, the GOP to gain the majority. Races to watch for medicine:

- **14th:** Incumbent Senator

Jeremiah Joyce (D-Cook) is being challenged by Donald W. Walsh. Senator Joyce's support for 1985 tort reform caught many of medicine's opponents by surprise.

■ **24th:** Incumbent LeRoy Lemke (D-Cook) faces a tough race from Bob Raica, assistant chief paramedic for the Chicago Fire Department. Lemke has been particularly unsympathetic to medicine's viewpoint on issues.

■ **26th:** Incumbent Greg Zito (D-Cook), friendly to medicine, faces a challenge from Vic Pilolla.

■ **29th:** Incumbent Roger Keats (R-Cook) has Burton Weinstein as his opponent. Weinstein, a trial lawyer, has the backing of the state's trial lawyers, while Keats has been a staunch supporter of medicine.

■ **36th:** Incumbent Clarence Darrow will be a candidate for judge of the circuit court of the 14th judicial circuit. Democrats nominated Denny Jacobs (Rock Island), the mayor of East Moline. The GOP candidate is H. Bud Ford.

■ **38th:** Incumbent Pat Welch, who strongly opposed caps on non-economic losses in 1986, faces a strong challenge from GOP DeKalb County Auditor, Tom Setchell.

■ **42nd:** Incumbent George Sangmeister (D) gave up this seat to run for Lt. Governor. Democrats nominated Thomas A. Dunn, while the GOP nominated Joliet Mayor John Bourg.

■ **47th:** The death of Senator Prescott Bloom created this race between State Representative Carl Hawkinson (R-Knox) and Tom Cassidy (D).

■ **48th:** Incumbent Laura Kent Donahue (R-Adams) is being challenged by trial attorney Hubert Staff. Donahue has always sponsored ISMS tort reforms.

■ **51st:** Incumbent James Rupp (R-Macon), strong and loyal supporter of issues of importance to medicine, faces a challenge from Penny Severns.

■ **53rd:** Harry "Babe" Woodyard (R-Edgar) the incumbent, another friend of medicine, faces Alan Holderfield.

■ **54th:** Incumbent William O'Daniel (D), a 1985 sponsor of medical malpractice reform, is being challenged by Charles Carpentier.

■ **59th:** Democrat incumbent Glenn Poshard faces GOP challenger Richard Simmons.

State House

The Illinois State House now holds 67 Democrats and 51 Republicans. The Democrats are expected to maintain their majority. Races of interest include:

■ **13th:** Incumbent Ralph Capparelli (D-Cook), a friend of medicine, vs. Carol Panek.

■ **14th:** Incumbent Roger McAuliffe, the only GOP Representative in the city of Chicago and a sponsor of medical malpractice reform, vs. Robert Wronski.

■ **27th:** Incumbent John McNamara (D-Cook) vs. Annette Dixon.

■ **43rd:** Incumbent Jack Kubik (R-Cook), a friend of medicine vs. Russell Hartigan.

■ **47th:** Democrat incumbent John O'Connell (Cook), who disappointed many in medicine when he refused to support medical malpractice reforms, vs. Anne Zickus.

■ **52nd:** Incumbent Linda Williamson, (R-Cook), a supporter of medical malpractice reform legislation vs. Geoff Obrzut, a former ISMS employee and current member of Speaker Mike Madigan's staff.

■ **58th:** Democrat incumbent Grace Mary Stern (Lake), not a supporter of medical malpractice reform, vs. oral surgeon, Robert Jans.

■ **69th:** Democratic incumbent Dick Mulcahey (Winnebago) vs. Mark McLeRoy.

■ **76th:** GOP incumbent John Countryman (DeKalb), who opposed medical malpractice reform, vs. Greg Sparrow, mayor of DeKalb.

■ **80th:** Incumbent Republican freshman, Robert Regan (Will) vs. Jim Marzuki, a rematch of 1984. Regan is a vocal supporter of caps on non-economic awards.

■ **82nd:** Incumbent Dennis Hastert (R-Kendall) is seeking the 14th Congressional seat. GOP nominee is Ed Petkas. No Democrat is on the ballot at this time.

■ **83rd:** Incumbent LeRoy Van Duyne (D-Will) vs. Joseph M. Jenco. Physicians were disappointed by Van Duyne's votes on the ISMS malpractice package.

■ **84th:** Incumbent Jack Davis (R-Will) is seeking the 4th Congressional seat. The GOP nominee is Larry Wennlund. The Democrats have nominated Charles Adelman.

■ **85th:** Democrat incumbent Ray Christensen (Grundy) vs. Republican challenger Jerry Weller. Representative Christiansen has not been a supporter of tort reform.

■ **90th:** State Representative Sam Vinson (R-DeWitt), loyal supporter of issues important to medicine, and a strong and able leader, has resigned this House seat. At this writing, a successor has not been chosen.

■ **94th:** Incumbent Carl Hawkinson (R-Knox) is seeking the Senate seat. GOP nominee is Dave Hultgren who will face Sam McGrew.

■ **95th:** Incumbent Kent Slater (R-McDonough), opponent of medical malpractice reform, vs. George Lipper.

■ **98th:** Democrat incumbent Gary Hannig (Macoupin) vs. Republican Becky Doyle. Hannig supported medical malpractice reform.

■ **99th:** Democrat incumbent Michael Curran (Sangamon) vs. Republican opponent Bob Nika, who supports medical malpractice reform.

■ **100th:** Incumbent Josephine Oblinger (R-Sangamon) retired from this seat. Republican Karen Hasara was appointed to finish out the term. She now faces Don Huddleston on November fourth.

■ **103rd:** Democrat incumbent Helen Satterthwaite (Champaign) vs. Brian Silverman, a supporter of medical malpractice reform.

■ **105th:** Republican Babe Woodyard (Edgar) left this seat vacant to run for the Senate seat. William Black (R) now will run against Larry Stuffle. Stuffle's most recent employment has been as an advocate for trial lawyers' issues, while Black has been supportive of ISMS positions in Springfield.

■ **109th:** Incumbent Dwight Friedrich (R-Marion) vs. Kurt Granberg, an attorney. Friedrich is GOP caucus chairman and a supporter of tort reform.

■ **110th:** Incumbent Ron Stephens (R-St. Clair) vs. Michael Slape, former Democratic representative. As a pharmacist, Stephens has been particularly sensitive to the need for relief from the medical malpractice crisis.

■ **114th:** Democrat incumbent Monroe Flinn (St. Clair), who withstood tremendous pressure from the trial lawyers and voted for the ISMS malpractice reform package important to medicine, vs. Robert Goins.

■ **115th:** Friend of medicine incumbent Wayne Goforth (R-Perry), vs. Jerry K. Thomas.

■ **116th:** Democrat incumbent Bruce Richmond (Jackson), a strong supporter of ISMS tort reform, vs. Herman Wright.

■ **117th:** Democrat incumbent Jim Rea (Franklin), a supporter of tort reform and other issues important to medicine, vs. Doris Boynton.

Physicians, their spouses, and others should carefully evaluate the Illinois General Assembly races in their communities and support and vote for those candidates friendly to medicine. For more information on any Illinois races, call the ISMS Governmental Affairs Division, 312-782-1654. ◂

It's Easy to Help Those Who Have Helped Us

What do the people in the box at right have in common?

They helped you and your patients by sponsoring proposals for medical malpractice reform in 1985. Now, they need your help: Your Vote.

You can't vote if you are not registered. You can register at your county clerk's office until Tuesday, October 7.

You can't vote if your registration isn't current. If you've moved or changed your name since the last election, be sure that the correct information is on file. See your county clerk to verify it by October 7.

You can't vote if you will be out of town on Election Day, Tuesday, November 4, 1986. But you can vote absentee:

1) Request an application for an absentee ballot from your county clerk no earlier than September 25.
2) Complete the application, including your name, home address and the address where you want the ballot to be mailed.
3) Mail or deliver the application. If you deliver it, you may immediately vote absentee (not more than 40 days nor less than one day prior to the election).

If you mail it, you may vote absentee not more than 40 days nor less than five days prior to the election.

After receiving the ballot, vote the ballot in secret, insert the ballot into the envelope provided, seal it, complete the certification on the back, and return it to the election authority in sufficient time for it to be delivered to the polling place on Election Day. It should be received by the county clerk no later than October 30.

Who should vote absentee?

1) Resident physicians and medical students who are Illinois voters, but are not living in their county of residence. Ask a family member to obtain an application for an absentee ballot.
2) Physicians and spouses who will not be in the county on election day.

Many fine candidates throughout the state deserve your vote. Please be an informed citizen and exercise your franchise.

The fate of legislation is decided not by the legislature when it meets, but by voters on Election Day.

Vote, Tuesday, November 4, 1986. ◂

Senators
Clarence Darrow (D-Rock Island)*
Laura Kent-Donahue (R-Quincy)
Adeline Geo-Karis (R-Zion)*
Jeremiah E. Joyce (D-Chicago)
William O'Daniel (D-Mt. Vernon)
James Rupp (R-Decatur)
Jack Schaffer (R-Crystal Lake)
Sam Vadalabene (D-Edwardsville)

Representatives
Robert Churchill (R-Antioch)
Lee A. Daniels (R-Elmhurst)
Loleta Didrickson (R-Homewood)
Thomas Ewing (R-Pontiac)
Bruce Farley (D-Chicago)
Virginia Frederick (R-Lake Forest)
Larry Hicks (D-Mt. Vernon)
Jack Kubik (R-North Riverside)
Roger McAuliffe (R-Chicago)
Thomas McCracken (R-Westmont)
Margaret Parcells (R-Glenview)
Alfred Ronan (D-Chicago)
Thomas Ryder (R-Jerseyville)
James Stange (R-Oak Brook)
Ron Stephens (D-Caseyville)
Mike Tate (R-Decatur)
Ronald Wait (R-Belvidere)
Jesse White (D-Chicago)

**Senator Adeline Geo-Karis (R-Zion) is a candidate for comptroller and Senator Clarence Darrow (D-Rock Island) is a candidate for judge of the circuit court of the Fourteenth judicial circuit. All others listed are incumbents seeking re-election to the Senate or House.*

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education

Medical Disciplinary Orders

- *Zarina Bandukwala (lic. #036-062340 & 003-036-062340)*
  Effective June 16, 1986, the medical and controlled substance licenses of Dr. Bandukwala were suspended, pending a later hearing.
- *Rosalba Gomez (lic. #036-52968)*
  Effective May 30, 1986, Dr. Gomez' medical license was suspended indefinitely.
- *Olga Ivsin (lic. #036-044569 & 003-036-044569)*
  Effective June 4, 1986, Dr. Ivsin's medical and controlled substance licenses were suspended.
- *Arthur C. Maimon (lic. #036-029596 & 003-036-029596)*
  Effective May 30, 1986, Dr. Maimon's medical and controlled substance licenses were indefinitely suspended.
- *Nicholas P. Mastores (lic. #036-026396 & 003-036-026396)*
  Effective June 26, 1986, Dr. Mastores' medical and controlled substance licenses were suspended, pending a later hearing.
- *Dean Pelley (lic. #036-45624 & 003-036-45624)*
  Effective May 25, 1986, Dr. Pelley's medical license was placed on a two year probation and his controlled substance license was suspended, but that suspension was stayed and the controlled substance license was placed on probation.
- *Paulette C. Trumm (license application)*
  Effective May 1, 1986, Dr. Trumm's application for a medical license was approved, but the license was placed on a probationary status.
  (Source: Orders received from the Director of DRE)

From the Department of Public Health (IDPH)

Abortion Regulations

IDPH has determined its response to a preliminary injunction which prevents the department from enforcing the Ambulatory Surgical Treatment Center (ASTC) Act and rules against any physician offering, performing or desiring to offer a first or early second trimester abortion. IDPH has taken the following positions:

1. Facilities which are devoted solely to abortions or abortion-related gynecological procedures are totally excluded from the jurisdiction of the ASTC Act and rules;
2. Facilities devoted primarily to the performance of surgical procedures which do not perform or offer abortions or abortion-related gynecological procedures are still within the jurisdiction of the ASTC Act and its rules; and
3. Facilities which are devoted primarily to the performance of surgical procedures (including abortions and abortion-related gynecological procedures) are within the jurisdiction of the ASTC Act and its rules, with respect to a facility's non-abortion procedures only. Abortions and abortion-related gynecological procedures may still be counted as "surgical procedures" under the definition of an ASTC, but are not subject to regulation by the IDPH under general or abortion-specific rules.

It appears that the effect of the injunction is temporary deregulation of any abortion-related services provided in Illinois. The Department has appealed the preliminary injunction. It is expected that oral arguments will be scheduled for the fall.
(Source: June 9, 1986 memo from IDPH Legal Council to Div. of Health Facilities Standards)

From the Guardianship and Advocacy Commission

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission is looking for physicians with the interest, time and expertise to serve as volunteer investigators.

The Human Rights Authority is a statewide panel of volunteers, appointed by the Commission, that conducts fact-finding investigations when complaints are filed alleging rights violations in private and public facilities that provide services to the disabled. The "Authority" is actually nine regional authorities. The alleged violations are usually systemic (conditions that affect more than one recipient) and involve mental and physical disability laws.

Although the Human Rights Authority is not an enforcement agency, it does have statutory power during an investigation to enter and inspect the premises of a services provider, to privately question any persons, to subpoena documents and the testimony

of witnesses, and to hold public hearings. It investigates the allegations and, if valid, recommends corrections to the facility. If a satisfactory resolution is not achieved, the matter may be referred to the Legal Advocacy Service or to another government body for further action. The Human Rights Authority's method of negotiation can be an effective alternative to formal legal action.

The Guardianship and Advocacy Commission is the state agency that protects and enforces the rights of the mentally ill, developmentally disabled, physically handicapped and disabled aged.

Interested persons should contact Gloria Prevost, director, Human Rights Authority, Guardianship and Advocacy Commission, 123 West Madison, Chicago, IL 60602, or call 312/793-5900.

(Source: Correspondence from Director, Human Rights Authority) ◀

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November, 1986-January, 1987

Sports Medicine
November 5-7, 1986
Fiberoptic Esophagogastric Endoscopy
November 10-12, 1986
Flexible Fiberoptic Sigmoidoscopy
November 15, 1986
Advances in Internal Medicine, 1986
November 17-21, 1986
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January 5-10, 1987

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Medical Director Inpatient Psychiatry

Our client is a not-for-profit multi-hospital system developing a contract management company to manage adult and adolescent hospital psychiatry units.

They seek a part-time Medical Director for a contract managed 50-bed inpatient psychiatry unit.

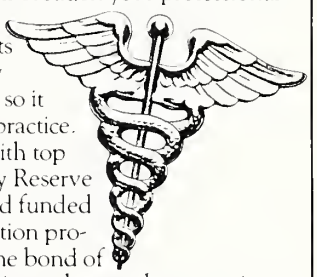
If you are a board-certified psychiatrist interested in taking on the challenges of an active unit located in Chicago, please send your curriculum vitae to:

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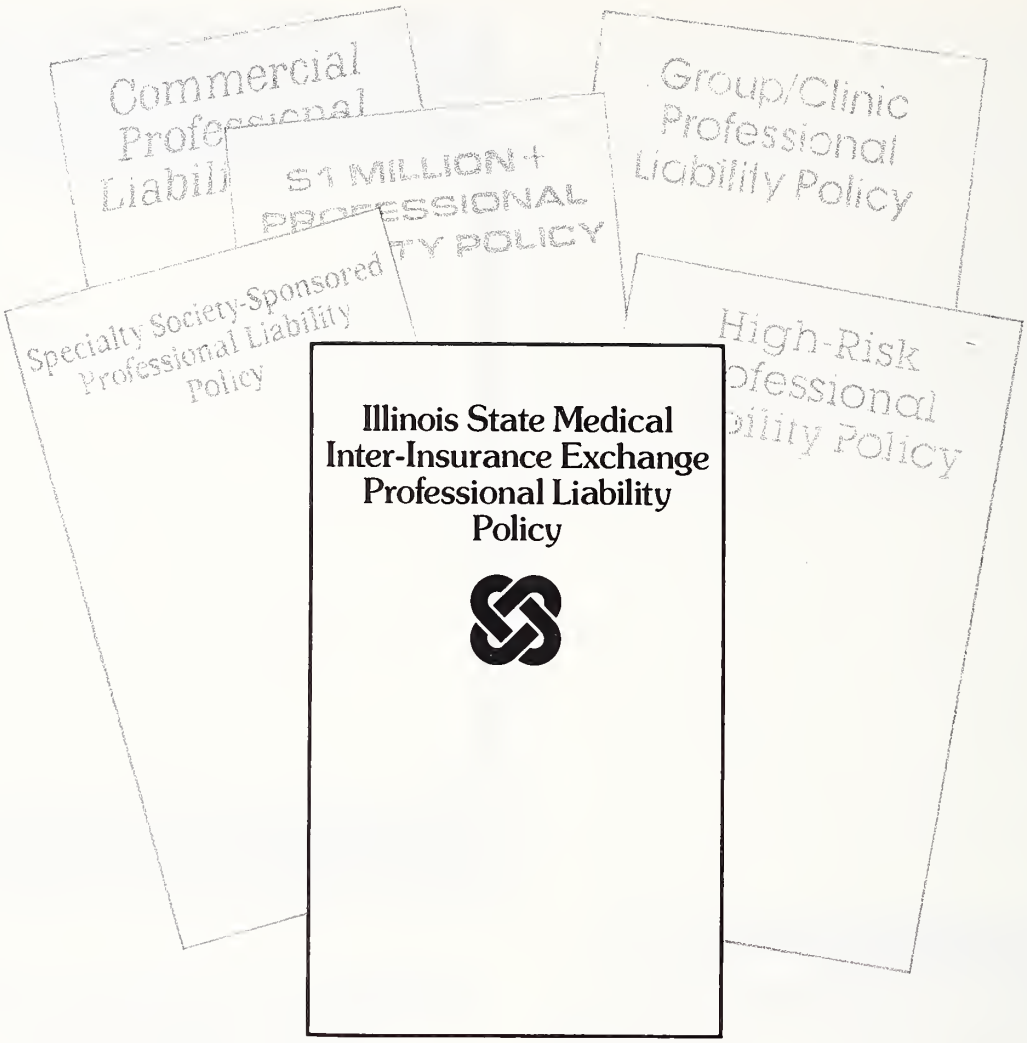
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As an Army Reserve physician, you can serve your country and community with just a small investment of your time. You will broaden your professional experience by working on interesting medical projects in your community. Army Reserve service is flexible, so it won't interfere with your practice. You'll work and consult with top physicians during monthly Reserve meetings. You'll also attend funded continuing medical education programs. You will all share the bond of being civic-minded physicians who are also commissioned officers. One important benefit of being an officer is the non-contributory retirement annuity you will get when you retire from the Army Reserve. To find out more, simply call the number below.



ARMY RESERVE. BE ALL YOU CAN BE.

Contact Captain Larry Landrum
(312) 926-3273



A disappearing act?

The number and size of damage claims against physicians continues to rise. And it's drying up most sources of malpractice insurance for Illinois doctors.

But there's one company that will still be here even if all the others are gone. The Illinois State Medical Inter-Insurance Exchange.

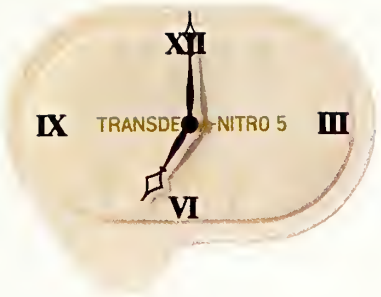
The Exchange is a company owned and operated by its policyholders. As such, we put our policyholders ahead of profit.

Unfortunately, the Exchange is not immune from the ravages of the current legal situation. The shrinking availability of backup insurance protection is forcing us to offer only claims-made policies after July 1.

But even with claims-made, we intend to make sure that Exchange policyholders will continue to have the best professional liability protection available. The sam aggressive defense of frivolous suits. And programs to help you avoid the incidents that can lead to malpractic suits.

The Illinois State Medical Inter-Insurance Exchange. There when you need it.

Illinois State Medical Inter-Insurance Exchang
Twenty North Michigan Avenue
Suite 700
Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (Toll-Fr



Puts in a full day's work

Transderm-Nitro®
nitroglycerin

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information on the following page.)

C I B A

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Transderm-Nitro®
(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26) *100 Systems (NDC 0083-2025-30)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

*Hospital Pack 100's

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C I B A

Membership

Catherine M. Hill, CMA/Palatine

As first vice president for the Illinois Society of Medical Assistants, (ISMA) my major goal is to increase membership and to promote the identity of the medical assistant and its professional organization.

When your medical assistant is a member, she/he receives educational publications, such as the *Professional Medical Assistant* journal, *Byline Newsletter*, and the *Illini Cardinal*, as well as a local newsletter in some instances. Other advantages of membership include approved continuing educational programs, guided study programs to advance medical knowledge, certification to prove professional competence, loans and scholarship funds and a variety of insurance benefits. But perhaps most important, membership allows the medical assistant to share in the interaction of learning, exchanging ideas, experiences, and feelings to promote professional growth.

Membership in a professional organization indicates a commitment to the profession. It demonstrates that the medical assistant sees his/her work as more than just a job where a paycheck can be received. Membership shows others (physicians, patients and co-workers) that the medical assistant has gone one step further to take pride in her/his profession.

In working with Ehlma Garcia, CMA-EMT-A, immediate past ISMA president and present membership chairman, we have been able to target four groups for membership efforts in the coming year: students, new graduates/CMAs, past graduates and present members.

Membership includes three levels: national, (American Association of Medical Assistants) state, (Illinois Society of Medical Assistants) and local. At the local level, Illinois presently has 15 chapters, and two new chapters are under formation.

Does your medical assistant know about his/her professional organization?

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, 1704 East Jackson Street, Bloomington, Illinois 61701; Robin Bluestein, CMA-C, Co-Chairman, public relations committee, 2247 West Estes, #2, Chicago, IL 60645; or Catherine M. Hill, CMA, Co-Chairman, public relations committee, 900 South Plum Grove Road, Palatine, IL 60067. ◀

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Illinois State Medical Society

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Four Adults with Ebstein's Anomaly

By Tim Ferguson, Suping Hsieh, Geoffrey Bland, M.D., and H. Weston Moses, M.D./Springfield

Ebstein's anomaly is a rare congenital disease with a variety of clinical presentations. These range from life-threatening heart failure in infancy to asymptomatic status with normal life span. We report four adult Ebstein's anomaly patients, two of whom have been diagnosed within the past year.

A 50-year-old man was admitted for evaluation of chest pain of four days' duration which had become increasingly severe. The pain was described as a dull ache in the left anterior chest radiating into his left forearm. He had no symptoms of heart failure, but related a lifelong history of heart murmur with no specific diagnosis.

On admission the patient was noted to have an irregularly irregular heartbeat. S1 varied in intensity while S2 intensity was diminished. He exhibited an S3 gallop and grade II/VI holosystolic murmur along the left sternal border. EKG revealed atrial fibrillation with a right bundle branch block, ST depression of the lateral EKG lead tracings and left axis deviation. Cardiac enzymes were within normal limits. Chest x-ray showed cardiac enlargement and possible pulmonary hypertension.

The patient was evaluated with M-mode and two dimensional echocardiography. A massively enlarged right atrium and a low-lying tricuspid valve in the right ventricle, diagnostic of Ebstein's anomaly, were revealed. Cardiac catheterization further supported the diagnosis of Ebstein's anomaly, showing a low-lying tricuspid valve and a reduced ejection fraction of .40. A 90% stenosis of a second marginal branch and elevated right heart pressures, as well as an elevated LVEDP, were also revealed.

The patient was discharged to be managed medically for single vessel coronary artery disease.

Case Report #2

A 59-year-old woman was admitted for evaluation of tachycardia and cyanosis. The patient had experienced palpitations for at least 20 years. She had been a "blue baby" and reported episodes of acrocyanosis even into childhood. After undergoing a cardiologic evaluation in 1968, the patient had been treated with propranolol and chlorothiazide. Her episodes of tachycardia were fairly well controlled on these medications. She had also recently been prescribed digoxin. History also included four uncomplicated pregnancies.

The patient had been admitted to an outlying hospital due to increasing dyspnea on exertion one week prior to her admission to our facility. Admission studies there indicated mild cyanosis, particularly in the perioral area and the extremities. Cardiovascular exam showed splitting of both S1 and S2, an S4 gallop and a grade II-III/VI systolic murmur along the left sternal border, but no right ventricular lift was appreciated. Abdominal examination indicated a pulsatile liver and hepatojugular reflux.

EKG showed rapid atrial fibrillation which converted to sinus rhythm with oxygen administration. Admission laboratory studies revealed hypoxia with a PO2 of 54 and an oxygen saturation of 87%. Hematocrit was 50 and hemoglobin was 18.1. Repeated blood gases in room air continued to show a saturation of 86%.

On admission to our facility one week later, the patient's physical findings were essentially unchanged. Admission EKG showed she was in sinus rhythm with frequent supraventricular premature complexes having aberrant conduction. Admission hematocrit was 50.9, hemoglobin was 17.6 and chest x-ray showed cardiomegaly. The patient subsequently underwent M-mode and two dimensional echocardiography, which revealed tricuspid valve abnormality diagnostic of Ebstein's anomaly with resul-

tant atrialization of the right ventricle. Doppler study demonstrated tricuspid regurgitation. Mitral prolapse was noted and ventricular wall motion was normal. Cardiac catheterization confirmed this diagnosis. In addition, an atrial defect considered to be a patent foramen ovale was seen and a small right-to-left shunt was documented. The patient had normal cardiac pressures and no abnormality of the coronary vasculature was seen. She was discharged to be managed medically.

Case Report #3

This patient was a 19-year-old man who had first presented at age 11 with otitis media and an accompanying tachycardia. He was noted to have a grade I/VI systolic murmur at the left lower sternal border. EKG, chest x-ray, echocardiography, and laboratory studies at that time were reported to be unremarkable except for leukocytosis accompanying the otitis. No specific diagnosis had been made.

He was readmitted later that same year complaining of chest discomfort, sweating, and dizziness. Serial EKGs were grossly abnormal, showing sinus bradycardia, paroxysmal atrial tachycardia, supraventricular tachycardia, frequent PVCs, and up to four-second periods of asystole. A repeat echocardiogram revealed mitral prolapse as well as a low-lying septal leaflet of the tricuspid valve with tricuspid prolapse. Ebstein's anomaly was diagnosed. The patient's brady-tachy arrhythmia required placement of a permanent pacemaker.

The patient has done well, although occasional episodes of SVT occur despite medication. At his most recent admission earlier this year for cervical lymphadenopathy, he was asymptomatic, with no change in cardiac status. EKG showed normal sinus rhythm.

Case Report #4

A 19-year-old woman in her third month of pregnancy was referred by her obstetrician for evaluation of congenital heart disease. Ebstein's anomaly had been diagnosed at cardiac catheterization, conducted at one year of age. Cardiac catheterization had shown normal O2 saturations and a deformed tricuspid valve with moderate tricuspid insufficiency. A repeat catheterization at age four had revealed significant tricuspid regurgitation, poor contractility of the right ventricle and downward displacement of the tricuspid valve into the right ventricle, as well as some deformity of the right ventricular outflow tract.

The patient reported an uneventful and asymptomatic childhood without limitation of physical activities. On physical examination in clinic she was at three months' gestation, appeared healthy and was normotensive. On cardiovascular exam, her PMI was not easily palpable. Testing for S1 was normal to auscultation, but S2 was significantly split. She had a grade II/VI systolic murmur at the left sternal border radiating into the axilla, but not the carotids. No diastolic murmur was noted. She had no jugular venous distention or ankle edema. The remaining exam was unremarkable.

The patient's EKG was normal. She underwent M-mode and two dimensional echocardiography which revealed an enlarged right ventricle, a thickened tricuspid valve and evidence of tricuspid valve prolapse. The valve was low-lying in the right ventricle, consistent with her diagnosis of Ebstein's anomaly. A very large right atrium also was revealed and Doppler echocardiogram diagnosed tricuspid regurgitation.

The patient completed her pregnancy to term without cardiovascular problems.

Discussion

Because of the broad spectrum of pathologic changes in Ebstein's anomaly, the hemodynamic alteration is variable. It is related to the severity of tricuspid valve incompetence, the presence or absence of an associated atrial septal defect and the degree of right ventricular function impairment.[1] The basic pattern of valve leaflet displacement is remarkably constant.[2] Only the septal and posterior (inferior) leaflet attachments are displaced, and the point of maximum displacement is at the commissure between these two leaflets.[2]

Although a few patients may be asymptomatic, cyanosis and dyspnea are present in the majority.[1] This occurs most commonly in those with an atrial septal defect or patent foramen ovale with a right-to-left shunt.

Of the four cases, only the second presented with cyanosis. She was found to have a patent foramen ovale by cardiac catheterization. Cases one and three presented with chest pain. Case one was determined to be angina secondary to single vessel coronary artery disease. Concomitant atherosclerosis is uncommon, but in 1981 Cabin, *et. al.,* reported a 72-year-old man with documented Ebstein's anomaly who died of ASHD.[3] In case three, the patient's chest discomfort occurred during episodes of bradycardia and prolonged asystole. Case four was completely asymptomatic.

Physical findings may be varied. Asymmetry of the chest may be noted.[1] Arterial and venous pulse forms are usually normal, but a large "V" wave may be seen in the face of significant tricuspid regurgitation.[1]

Auscultatory findings may reveal S1 splitting.[1] S2 is widely and persistently split by the delay in pulmonary valve closure due to right bundle branch block[1] when present. S2 may also be normal or diminished in quality.[1] Both atrial and ventricular filling sounds are relatively common, and contribute to the multiple sounds and cadence quality so often associated with Ebstein's anomaly.[1]

No abnormal pulses were noted in our patients, although one exhibited hepatojugular reflux. The patient in case one had splitting of S1 as well as a diminution of S2. Cases two and four had splitting of S2. All patients had varying grades of systolic murmurs and Cases one and two had additional S3 or S4 gallops.

Electrocardiogram testing is often nonspecific, and most patients present in sinus rhythm. The Wolff-Parkinson-White pattern may be seen in a small percentage of cases, however.[1] When seen in a cyanotic patient whose history includes palpitations, it is highly suggestive of this anomaly.[1] The most commonly seen dysrhythmias are supraventricular tachycardias which are not necessarily related to accelerated or anomalous atrioventricular conduc-

Figure 1

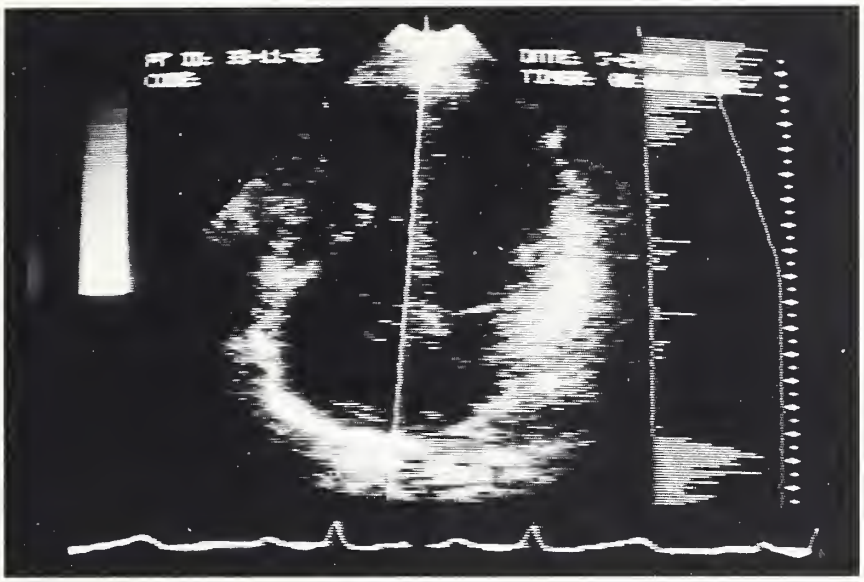


Figure 1a
Apical four chamber view of a two dimensional echocardiogram.

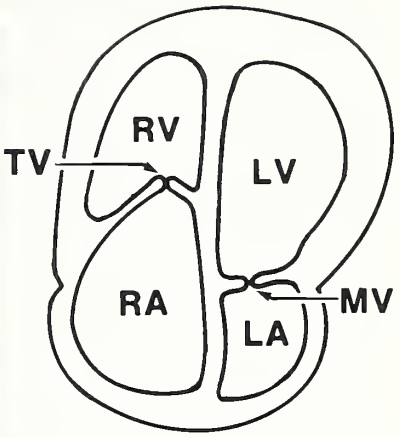


Figure 1b
Depiction of the low lying tricuspid valve (TV), small right ventricle (RV), and enlarged right atrium (RA). Normal left ventricle (LV), left atrium (LA), and mitral valve (MV) are also seen.

tion.[1] P-wave peaks may range from normal to large.[1] There is often prolongation of the P-R interval. QRS axis often shows deviation, usually to the right but occasionally to the left. The QRS complex may be prolonged and of low voltage, frequently exhibiting a right bundle branch block pattern in the right precordial leads.[1] Small initial Q-waves are found in 50% of patients, with the Q-wave occasionally seen in leads as far as V4.[1]

Two of our patients presented in atrial fibrillation, one of whom had an accompanying right bundle branch block. The other, after converting to sinus rhythm, had frequent supraventricular premature complexes with aberrant conduction. Of our two young adults, one presented with cardiac electrical activity requiring placement of a permanent pacemaker, while the other had a completely normal EKG.

Chest x-rays may appear normal, but in a majority of cases, the heart appears balloon-shaped, similar to that seen with pericardial effusion with a narrow waist.[1] The enlarged right atrium will produce a rightward curvature in PA view, while in the lateral view, the atrium may fill the entire retrosternal space.[1] Dilatation of the right ventricular outflow tract produces varying degrees of displacement of the upper left cardiac border, as seen in the frontal views.[1] In cyanotic patients the vascular pattern is decreased because of the right-to-left shunt.[1]

Three of our four patients exhibited cardiomegaly, as seen on chest x-ray. One patient's lung markings suggested pulmonary hypertension. This, however, proved to be incorrect when pulmonary artery pressures measured at the time of cardiac catheterization were normal.

The echocardiogram is often diagnostic of Ebstein's anomaly. The most reliable criterion for diagnosis is the relationship of mitral valve closure to tricuspid valve closure,[1] as recorded by M-mode echocardiography. If tricuspid closure is more than 50 milliseconds after mitral valve closure, Ebstein's anomaly should be considered. The apical four-chamber view of two-dimensional echocardiography will often show the displacement of the tricuspid valve deep within the right ventricle. (Figure 1)

Our patients were diagnosed using the apical four-chamber view. All had easily identifiable displacement of the tricuspid valve. The M-mode echocardiogram supported our diagnosis, but was not diagnostic in itself.

Tricuspid valve replacement surgery is often the treatment of choice in the Ebstein's patient with severe cardiovascular compromise. Those with a milder form of the disease can be well-managed medically.

Ebstein's anomaly is an often fatal affliction. Approximately 70% survive to age two, 50% to age three, and less than 5% beyond age 50.[1] In 1974 Watson reported on 505 cases of Ebstein's anomaly in pediatric and adolescent patients.[4] This international cooperative study involved 61 centers in 28 countries. It focused on children and adolescents because prevalence is higher in these groups. Of the 61 centers in the study, only 17 collected more than ten cases.[5] We currently have four cases of adult Ebstein's anomaly in our clinic. Two of the four were diagnosed in childhood and have survived into adulthood. The other two were diagnosed for the first time only recently.

Those who do survive into an

advanced age are often discovered when evaluated for other cardiovascular diseases. The increased capabilities of today's M-mode and two dimensional echocardiography provide an easy, non-invasive way of discerning Ebstein's anomaly. The increased use of the echocardiogram and an aging population might well lead to an increase in the number of adult patients diagnosed with mild Ebstein's anomaly.

Acknowledgement

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References

1. Giuliani, E.R., Fuster, V., Brandenburg, R.O., Mair, D.D.: "Ebstein's Anomaly—The Clinical Features and Natural History of Ebstein's Anomaly of the Tricuspid Valve," *Mayo Clin Proc* 54: 163-173, 1979.
2. Anderson, K.R., Zuberbuhler, J.R., Anderson, R.H., Becker, A.E., Lie, J.T.: "Morphologic Spectrum of Ebstein's Anomaly of the Heart," *Mayo Clin Proc* 54:174-180, 1979.
3. Cabin H.W., Wood, T.P., Smith, O., Roberts, W.C.: "Ebstein's Anomaly in the Elderly," *Chest* 80:212-214, 1981.
4. Watson, H.: "Natural History of Ebstein's Anomaly of the Tricuspid Valve in Childhood and Adolescence: An International Co-operative Study of 505 Cases," *Br Heart J* 36:417-427, 1974.
5. Hansen, J.F., Leth, A., Dorph, S., Wennevold, A.: "The Prognosis in Ebstein's Disease of the Heart," *Acta Med Scand* 201:331-335, 1977.

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Interference By Severe Serum Lipemia

Radioimmunoassay of Beta HCG

By Barbara McFarlin, R.N., C.N.M., M.S.
And Suzanne Trupin, M.D./Urbana

Radioimmunoassay of serum B-HCG has been found to be a very sensitive and specific test to aid in the early diagnosis of pregnancy. Although serum B-HCG is an accurate test when using non-lipemic serum, it can give misleading results when the serum is lipemic. We report such a case. Serum lipemia interferes with retrieval of the B-subunit in the precipitation step of the radioimmunoassay. For lipemic specimens, ultracentrifugation of the serum prior to testing is necessary for an accurate result. This and other clinical conditions may influence the accuracy of serum B-HCG tests.

Human Chorionic Gonadotropin (HCG) is a placental protein elaborated in abundant quantities by trophoblastic tissue. Its measurement forms the basis of all standard pregnancy tests. Like other glycoprotein hormones, it is composed of alpha and beta subunits. The beta subunit is unique to this hormone alone. A specific radioimmunoassay (RIA) for HCG has been developed by using antibody to the beta subunit. All the tests employing urine examination give lengthy lists of possible factors which contribute to false positive and false negative test results. The obstetric literature indicates that serum radioimmunoassays employed are highly specific and sensitive for the beta subunit HCG. Factors that interfere with the test accuracy have not been previously identified in this literature.[1-3] We report a case of severe serum lipemia in an undiagnosed diabetic. Presence of blood fats gave a false positive beta HCG reading.

Case Report.

A 32-year-old, gravida 5, para 2, black female weighing 185 pounds presented reporting four months' amenorrhea, fatigue, nausea, anorexia, and urinary frequency. Pelvic examination demonstrated a normal multiparous uterus and no adnexal masses. These findings were confirmed by sonography. Initial laboratory evaluation included a positive beta subunit HCG radioimmunoassay and a random blood sugar of 400mg/dl. Severely lipemic serum was noted by the laboratory technician.

The patient was admitted for evaluation and stabilization. Further laboratory evaluation included a fasting blood sugar of 316mg/dl, fasting serum triglyceride of 3354mg/dl (nl 30-165), and fasting serum cholesterol of 296mg/dl (nl 140-300), a negative sickle cell preparation and a total urinary protein of 656 mg/24 hrs (nl 0-100 mg/24 hrs).

A repeat RIA beta HCG test (utilizing a different test) was still positive, indicating a value over 40mIU HCG. However, repeat RIA and an enzyme immunoassay after serum ultracentrifugation finally revealed an accurate negative HCG result. A quantitative beta HCG was done on serum only after ultracentrifugation. A value of $\leq$5mIU was reported, indicating a negative pregnancy test. Hospital lab personnel recognized the need to do ultracentrifugation of the specimen, prior to doing the quantitative beta subunit assay.

Depending upon the accuracy desired and the titer of the HCG being tested, various tests can aid in the early diagnosis of pregnancy. The first test utilized was a competitive binding assay.[1] A precipitating antiserum reagent separates beta-HCG antibody-bound tracer from unbound tracer. The second test performed also utilized the double antibody technique; I^{125} labeled HCG as the tracer.[4]

Radioimmunoassays are based on the principles of competitive protein binding. The sample to be tested is incubated with a known quan-

tity of antibody and radioactive (I^{125}) labeled antigen. The labeled and unlabeled patient sample antigens compete for binding sites on the antibody during incubation. The process is stopped by adding a second antibody which precipitates the antigen-antibody complexes. Following centrifugation, the precipitate is isolated (retrieved) by decanting off the supernatant. The antibody-bound tracer in the precipitate is counted by a gamma counter.

Serum lipemia interferes with retrieval of the beta subunit HCG test antigen during the centrifugation and decanting process. The blood fats are left in the precipitate preferentially over bound antibody, giving very low counts of the known tracer. As a result, the test reading is falsely positive. Ultracentrifugation of the serum to remove the excessive lipids is necessary for an accurate test. Interference with the test by lipemia, turbidity, (inaccurate spectrophotometry) and hemolysis (releasing proteins which have their hormonal receptors), is mentioned in the test kit literature of some,[4,5] but not all, of the kits.[1]

Enzyme immunoassay techniques for the qualitative and quantitative determinations of HCG do not involve a precipitation step. The beta HCG is immobilized by antiserum on polystyrene beads and then measured by spectrophotometry. The product information with these tests also mentions that lipemia or severe serum hemolysis can interfere with test accuracy, specifically the spectrophotometry.[5]

Summary

Clinicians must be aware of the limitations of the various serum beta HCG tests, and identify factors which may lead to misleading results. In this case, in spite of some documentation of the problems with serum lipemia, the clinicians and laboratory technicians in three labs were unaware of the test limitations. This led to inappropriate specimen preparation. Eventual correlation of clinical suspicion and laboratory analysis led to recognition of the problem and a correct diagnosis. ◀

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References

1. GammaDab, M.: "Clinical Assays," Travenol-Genentech, Cambridge, Mass. (product information).
2. Pritchard, McDonald, Gant: Williams Obstetrics, Seventeenth Edition, New York, Appleton, Century, Crofts, 1984.
3. Danforth, D.: Obstetrics and Gynecology, Fifth Edition, Philadelphia, Harper and Row Publishers, 1986.
4. "Beta-CG Radioimmunoassay," Roche Diagnostic Systems, Nutley, New Jersey (product information).
5. "Abbott B-HCG 15/15," Abbott Laboratories, Diagnostics Division, North Chicago, Illinois (product information).

"Sunset" Provision Raises Concerns

Medical Practice Act Scheduled for Reconsideration

Without action by the Illinois General Assembly, the practice of medicine will cease to exist in the eyes of the law on December 31, 1987. On that date the state's Medical Practice Act is scheduled to automatically expire or "sunset." Lobbying for extension of the practice act will be a major focus of Illinois State Medical Society (ISMS) activities during the spring session of the legislature. The Society's task will be made more difficult by its intention to pursue simultaneous legislative efforts to obtain a cap on non-economic damage awards and a revised statute of limitations in malpractice cases. These items will be addressed at the ISMS All-Member Conference November 8.

Even without the malpractice-related issues on the ISMS legislative agenda, the Society can expect to face a difficult time with respect to the Medical Practice Act. Non-physician groups are expected to raise proposals in conjunction with the sunset debate. They may seek mechanisms to cut physician fees or attempt to equate some allied health professions with physicians. Medical discipline remains a major issue and many groups favoring more stringent regulation of the medical profession can be expected to tinker with the Act as it winds its way through the legislative process.

Several proposals defeated during the 1986 General Assembly session may resurface as proposed revisions to the Medical Practice Act. These include:

- An increase in medical license fees to $500 annually;
- Mandatory retesting for medical licensure;
- Automatic license revocation for a specified number of malpractice suits; and
- Wider access to confidential peer review records.

The situation is complicated in that licensing acts governing many other health professionals are expiring at the same time. It's likely that the legislature will also face efforts by allied health professionals to expand their own spheres of practice.

Texas Experience

The complex and volatile nature of the sunset situation is poignantly illustrated by the experience of Texas physicians several years ago. That state's medical practice legislation was "held hostage" by a powerful legislative leader who demanded that optometrists be accorded the right to use prescription drugs for diagnostic purposes.

Kim Ross of the Texas Medical Association (TMA), characterized the situation as "good old fashioned brinkmanship." Ross, who recently returned to TMA as public affairs director, was a TMA lobbyist when the controversy raged in 1981.

Ross said the speaker of the Texas House of Representatives had called for an optometric drug provision and, when he was unable to round up enough votes to adopt the amendment, used his prerogative as speaker to block passage of the entire medical practice legislative package.

In turn, Texas physicians took a hard line, refusing to accede to the speaker's demand for use of drugs by optometrists. With no accord, the legislative session ended without action to extend the law that allowed physicians to practice medicine. However, the expiration of existing law was still two months away, leaving time for the state's governor to call a special session of the legislature. A compromise was reached during that special session, with the new practice law allowing use of diagnostic medications by optometrists under standing orders by ophthalmologists.

Expansion of optometric practice was not the only allied health-related issue that arose during debate over medical practice legislation, according to Ross. He said that sunset provisions in the state's health professional legislation "totally scrambled the legislative process," and prompted some allied health groups to seize it as an opportunity, "like a letter to Santa Claus."

One proposal defeated through TMA's efforts would have allowed nurses to diagnose and treat illness and perform minor surgery. Other amendments successfully opposed by TMA included those that would have permitted the independent practice of physical therapy, and more control by pharmacists of what drugs physicians could dispense in their offices.

Advice for Illinois

When asked what advice he might have for Illinois physicians regarding the upcoming legislative session, Ross warned that Illinois physicians should expect a multitude of issues during legislative debate over the Medical Practice Act.

The TMA public affairs director predicted that legislative leaders will play a key role in debate over Illinois legislation. In Texas, he said, the absolute need for passage of a bill gave considerable leverage to legislative "gatekeepers" in key positions.

Ross especially stressed the need for physicians to begin working with legislators well in advance of the debate over actual legislation. And he recommended that the medical profession take the initiative to correct any deficiencies in existing legislation before debate begins.

Opportunity

The medical profession's legislative groundwork is expected to be laid this fall in advance of the 1987 session. Manuevering over the Medical Practice Act and the latest ISMS malpractice reform initiative will be major topics discussed at the ISMS All-Member Conference, November 8, at the Drake Oakbrook hotel. Also, physician action teams from hospital medical staffs and county medical societies will be meeting with local legislators to discuss their concerns relative to these important issues.

While perhaps fraught with peril, the "opening" of the Medical Practice Act also carries with it some opportunities. For example, ISMS is expected to come forward with legislation embodying the recommendations made by the special task force created by Governor James R. Thompson to address medical discipline in Illinois. The Society also will again attempt to secure legislation permitting physicians to collectively discuss the terms and conditions of contracts offered by PPOs and other medical care delivery entities. ◀

Medical Practice Act Defined

The Illinois Medical Practice Act is the major body of law that governs activities of doctors of medicine, osteopathy, and chiropractic. Its major provisions can be loosely grouped into two main sections: legal requirements for physician training and licensure and the disciplinary process for dealing with violations of the law.

Licensing Requirements

The Medical Practice Act defines what educational training fulfills licensure requirements. A distinction is made for a license to practice medicine in all of its branches (MDs and DOs) and a license to treat human ailments without the use of drugs or surgery (chiropractors).

The Act stipulates which examinations must be successfully completed for licensure. It outlines the requirements medical graduates must meet and delineates parameters for reciprocal licensure with other states.

Sections of the Medical Practice Act also define the role and composition of the Medical Practice Examining Committee. That committee has oversight responsibility for the licensing process.

Discipline

Disciplinary provisions of the Act define the types of actions that can result in disciplinary proceedings against a physician. Also defined are the sanctions that may be imposed relative to a physician's ability to continue practice.

Language in the Act defines the role and makeup of the Medical Disciplinary Board. The disciplinary board, comprised of five MDs, one osteopath, and one chiropractor, ensures a medically-dominated peer review process in all disciplinary actions. The Act also contains the "mandatory reporting" provisions that require hospitals, medical societies, state agencies, and other entities to report any disciplinary actions against physicians to the Medical Disciplinary Board.

The agency charged with administering the Medical Practice Act is the Illinois Department of Registration and Education. The Department is empowered to promulgate rules and regulations to implement and enforce the law as it pertains to medical practice.

The Case for Caps

Legislative action to limit non-economic damages in medical malpractice cases is a key item on the ISMS agenda for professional liability reform this year. Some background on the issue, which will be explored in depth at the ISMS All-Member Conference November 8, might be enlightening.

When thousands of Illinois physicians left their practices to march on the state capitol in May of 1985, legislators came to agree that the malpractice problem truly had reached crisis proportions. And when the Illinois Supreme Court reviewed challenges to the new legislation, they determined that the legislature's response was, for the most part, appropriate.

Fueled by the success of the 1985 effort, the state's physicians—led by the Illinois State Medical Society—are girding for another campaign to educate legislators and the public. They hope to find legislative support for two elements critically important to a lasting solution to the malpractice problem. First, they will seek a revised statute of limitations in cases pertaining to treatment of minors. Second, they will pursue a cap on awards for non-economic factors, such as "pain and suffering" and "loss of consortium."

After the legislature convenes in January 1987, ISMS will offer legislation that would place limits on non-economic recoveries and the time period during which suits involving treatment of minors can be filed. Stiff and effective opposition is expected from plaintiff attorneys, who opposed the 1985 malpractice legislation and the 1986 general tort reform proposals. The trial attorneys, who were caught napping in 1985, will be ready in 1987.

Fair Limits Advocated

The ISMS proposals are intended to place fair limits on two aspects of malpractice suits which place undue burdens on defendants and their insurers. Jury verdicts in malpractice cases can be erratic and even wildly inappropriate. The same injury can produce considerably varied compensation in different circumstances—often due to huge non-economic damage awards.

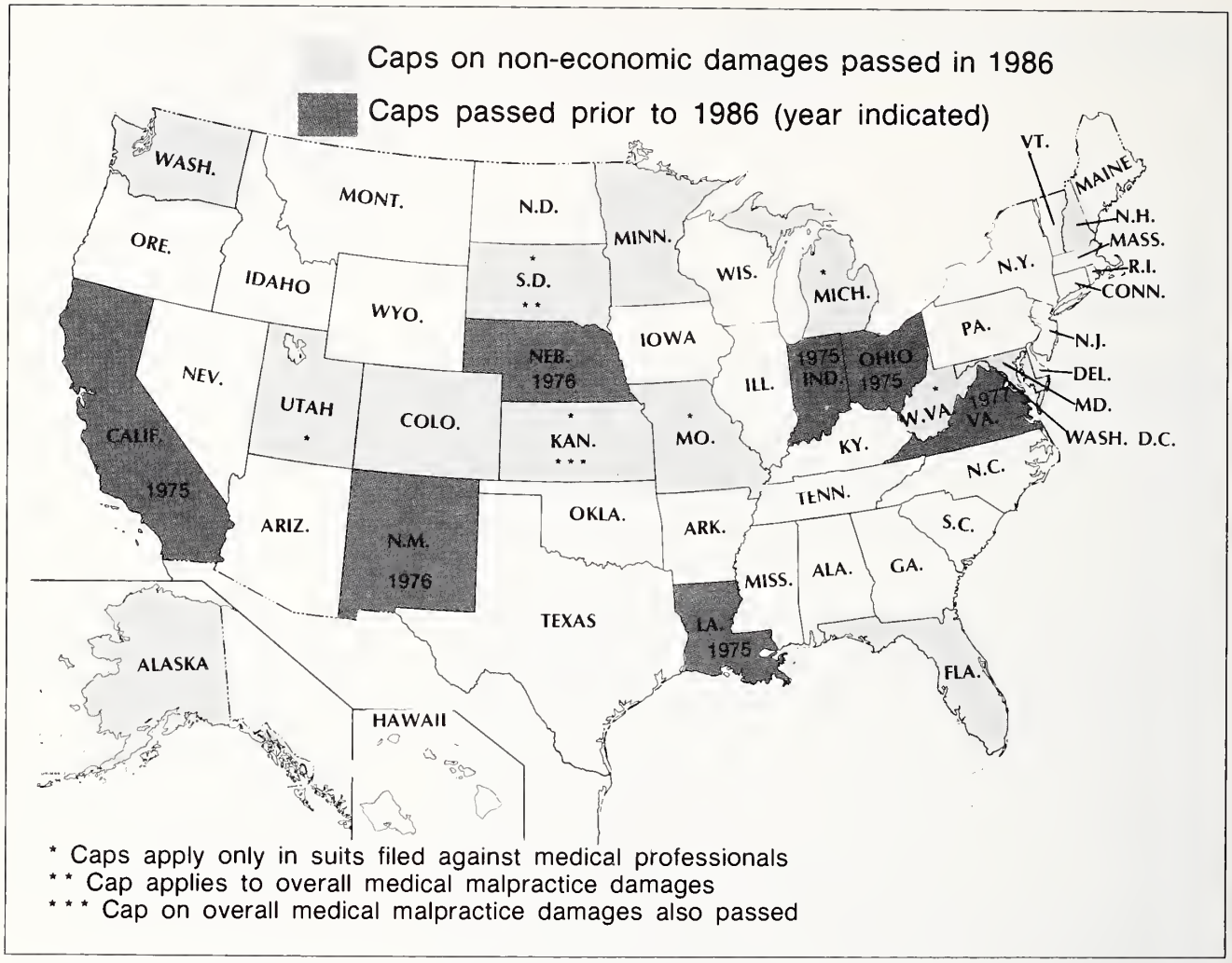
Juries determine amounts of non-economic damages. But there is no formula to translate non-economic considerations into economic terms. Non-economic considerations are impossible to quantify and emotional factors play a significant role. Without any guidelines or standards, juries may grant verdicts ranging from little or nothing to millions of dollars.

Caps Contain Costs

The potential for huge non-economic damages translates directly into higher insurance premiums. Capping non-economic losses could have a measurable impact on those costs:

- A study for the Pennsylvania Emergency Task Force to Examine Medical Liability Insurance revealed that a $250,000 cap would save 6-11%. Potential savings from a $100,000 limit were pegged at 17-25%.
- A similar study for the New York Liability Reform Coalition predicted a 25% savings with a $100,000 cap.
- In Illinois, a review of claims paid by the Illinois State Medical Inter-Insurance Exchange revealed that 10% of all indemnities paid during the past 10 years—some $15 million—would have been saved with a $250,000 cap.

One state with a cap on non-economic damages is California. That state's $250,000 limit is having a measurable effect. The 150% average premium increase since 1975 has been half the national average, according to the NORCAL Mutual Insurance Company in San Francisco. Last year's average premium hike was 15%, while the cor-



Map denotes states that have passed legislation capping damage awards for non-economic factors. ©1986, *American Medical News.* Reprinted with permission.

responding national figure was 33%.

Other States Seeking Caps

Buoyed by California's experience, physicians in other states are seeking similar lids on non-economic awards. At least 13 states have passed such legislation, according to *American Medical News.* Legislation in seven of those states was broadened beyond medical malpractice to include all civil cases. In addition, two states—Kansas and South Dakota—have placed a $1 million ceiling on general damages, including economic loss, *American Medical News* reported. (See accompanying map.)

The prospects for achieving legislation limiting non-economic damages were strengthened considerably by the U.S. Supreme Court's refusal to hear a challenge to the California legislation. The Court ruled that the challenge to the limit raised no substantial federal constitutional question.

ISMS legislative initiatives have consistently maintained that patients injured through medical negligence should receive full reimbursement of all *economic* hardships caused by the injury, including medical expenses, lost wages, and support of dependants. But ISMS believes that a limit on non-economic recoveries is a fair mechanism to contain skyrocketing insurance costs and preserve the availability of coverage.

Filing Limitations Also Sought

In another effort to bring fairness to the system, ISMS will seek to amend the statute of limitations that defines the time period during which a suit may be filed on the basis of an alleged incident of negligence. The law now permits suits up to two years after discovery of an alleged injury and/or four years after the actual date of treatment. For minors, however, the statute does not apply until the age of 18, leaving physicians vulnerable to suit for more than 20 years.

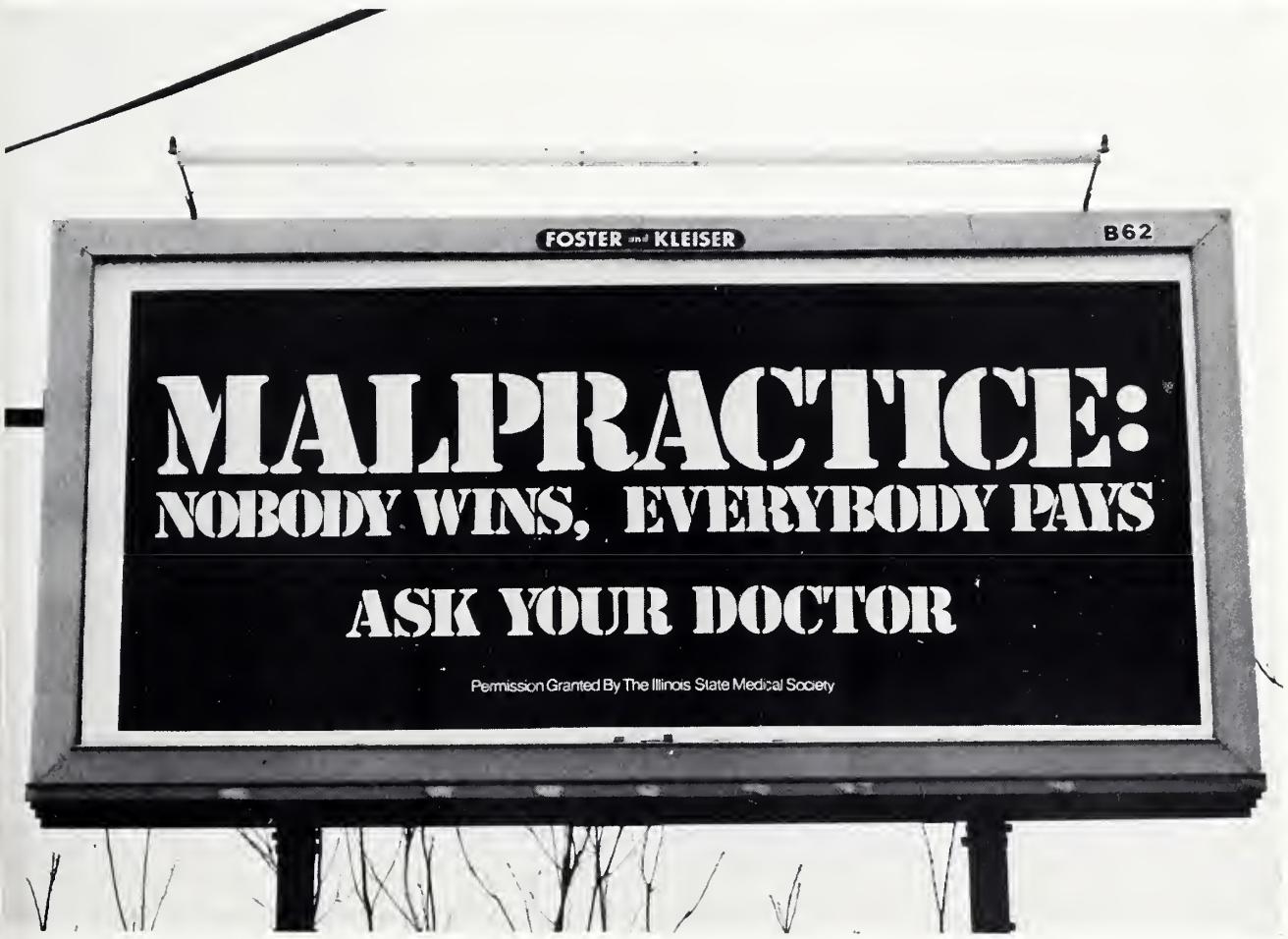
Suits resulting from incidents dated years before can be extremely difficult to defend. Pertinent wit-

nesses and records may be difficult or impossible to locate. Also, because the standards of care at the time of treatment were undoubtedly less sophisticated, the physician's actions may not be judged fairly when viewed from a current perspective. Inflation in the general economy plays a significant role in increasing the size of damage awards when cases are settled many years after an alleged incident.

These factors all translate into higher insurance costs for physicians, and in turn cost patients and their health insurers more. Because of the high costs and the threat of a loss that could exceed coverage limits, physicians may abandon obstetrics and high risk pediatrics. This could lead to less access to care for expectant mothers and children.

As with caps on non-economic damages, experience shows that tighter limitations on suit filings has a measurable impact on costs. For example, according to the Institute for Civil Justice, the savings are approximately eight percent for each year by which a statute of limitations is reduced. (The Institute's assessment applies to statutes for all cases, but revising the portion pertaining to minors is still expected to have a significant effect.)

ISMS believes that a revised statute of limitations concerning minors can bring balance to the system. On one hand, parents and guardians will still be assured adequate time to identify medical injuries, pursue legal remedies, and receive full compensation for all economic loss. On the other hand, with reasonable exposure to lawsuits, physicians would have a fairer chance to defend themselves. Insurance rates could be predictable and controlled. And threats to the availability of medical care could be alleviated. ◀



The Medical and Chirurgical Faculty of the State of Maryland forwarded this photograph of a billboard erected in their state to educate the public about the malpractice crisis. Proof positive that the Illinois message has traveled cross-continent!

First of Two Parts

Revolution Comes Slowly To the Law



Saul J. Morse, J.D., the principal of Saul J. Morse & Associates, Ltd., a Springfield law firm concentrating in governmental, health and administrative law, has been legislative counsel to the Illinois State Medical Society since 1977. He has served as minority legal counsel to the Illinois Senate and a trial attorney before the U.S. Commerce Commission. Mr. Morse is a member of the Illinois Human Rights Commission, vice-chair of the American Bar Association Medicine and Law Committee of the Tort and Insurance Practice Section and a member of the Illinois State Bar Association Committee on Insurance Programs.

We asked Mr. Morse to give us a legal and legislative perspective on the medical malpractice reforms passed in 1985, the Illinois Supreme Court ruling and the agenda for action in 1987. This month we present the first of two installments from that interview, covering activities to date. The November issue will feature the agenda for 1987.

IMJ: *Please describe the Medical Malpractice Law of 1985. How will it ease the malpractice climate?*

Saul Morse: The Medical Malpractice Reform Act of 1985 was complex legislation which evolved to fulfill diverse needs in the medical malpractice arena. I'd be hard pressed to place the provisions in order of importance, so I'll just comment on them as they come to mind.

Itemization of verdicts should affect litigation on a number of levels. Jury verdicts subject to itemization will be more rational. Emotional factors are less prominent when the decision must be tied to a series of isolated facts. Itemization will give us a sense of how juries value different injuries and instances of negligence. And it's important from the technical standpoint of insurance underwriting.

It's also important because we can't be in the jury deliberation room. We are not privy to all the discussions. We don't know what's important to the jury and what's not. If a verdict comes back with a lump sum, it's difficult for us to determine whether the jury followed the evidence that was given them or responded on an emotional basis. We hope that itemized verdicts will help jurors to hone in on the evidence presented to them and ensure that the verdict bears a direct relationship to the evidence.

Itemized verdicts should give defense attorneys and physician defendants some understanding of the thinking behind jury verdicts. It should enable them to leave the courtroom with a sense that there's some rationality to the system. It's also important because if we honestly believe that what the jury has done is not rational and does not bear a real relationship to the evidence, we have a much better basis on which to appeal.

IMJ: *The new law also requires an affidavit and consultant's report. What difference will that make?*

Saul Morse: The plaintiff's attorney must now attach a special affidavit and consultant's report to every complaint when it's first filed. The lawyer's affidavit and consultant's report must explain what standard of care the defendant physician violated and describe the theory for the plaintiff's case.

This is important for a lot of reasons. Some people feel that plaintiffs are filing cases for no reason whatsoever, when they're just unhappy. There's also a sense that some experts are so available that they act almost as hired guns. Whether or not those impressions are valid, we do have an incredible number of frivolous suits.

Requiring that the affidavit be attached to the complaint tells the defendant doctor what he's accused of, and it lets us know how best to defend him. When we know what they're really charging, we can focus on those issues.

Focusing right in on the issues at the outset should enable us to eliminate a lot of frivolous cases—maybe even before they're filed. It's our hope that plaintiff lawyers will not get bogus reports and that if they can't get a good, sound report, they won't file the case.

This should make some plaintiff lawyers' jobs a little easier. Sometimes they have to say to a client, "No, you don't have a case," and that's not always easy to do. Everyone who reaches the point of going to a lawyer is convinced that they've got a great case. We hope that the affidavit and consultant's report will avoid frivolous filings.

When questionable or marginal cases are filed, we hope to speed resolution by making appropriate motions to dismiss. The motion can be supported by expert testimony refuting the affidavit that was submitted with the complaint. That should speed cases along and also should narrow the issues. It may get us down to the real meat of the problem more quickly. And the quicker the case is settled or disposed of, the better it is for everybody.

The affidavit section of the law also permits the defendant physician to seek attorneys' fees from the plaintiff or his attorney if an inaccurate or untrue report is filed. We really hope that this will make people much more careful in filing lawsuits. For the first time, it will be less like a lottery. Plaintiffs will understand that if they don't have a valid case they may be required to pay some of the physician's costs.

We hope that itemized verdicts will help jurors to hone in on the evidence presented to them and ensure that the verdict bears a direct relationship to the evidence.

IMJ: *Do you think the counterclaims provision will be an effective deterrent?*

Saul Morse: The counterclaims provision will pertain to frivolous cases resolved by judgment without payment to the plaintiff. Many physicians will remember about ten years ago, when Dr. Leonard Berlin, a Skokie radiologist, brought a successful counterclaim against a former patient who had filed a frivolous case. Dr. Berlin was successful at the trial court level, although counterclaims had generally been precluded by Illinois law.

The number of malpractice filings fell off dramatically after his success became known. Plaintiffs came to realize that if they lost in court, or if there was a showing that their case had been recklessly brought, the physician could get fees and costs. Many people decided not to file. Unfortunately, Dr. Berlin's case was later overturned by a higher court and filings increased once again.

One of the big problems we have as a professional group is that for physicians, the non-monetary costs of a malpractice suit are very significant. A suit affects the way a physician practices and poses myriad difficulties even if he wins. Physicians make a great personal investment in their livelihood—it's not just business to them.

Frivolous or not, each and every case incurs substantial expenditure. We can spend thousands of dollars on the most frivolous case just to compensate for staff time and attorneys' fees. We can hope to weed out the really bogus cases by showing potential plaintiffs that if they bring a frivolous action we can file a counterclaim for the physician's costs. That should hold our costs down and might allow malpractice insurance premiums to level off—or at least stop skyrocketing. We're really hoping that the threat of a counterclaim will discourage people from filing frivolous lawsuits in the first place.

IMJ: *Tell me about the provision to exclude irrelevant parties.*

Saul Morse: That provision allows a motion to dismiss when it can be shown that the physician was not involved. We could do that before this law was passed, but the problem was that the motion would lie dormant for months or years while the rest of the case went on and discovery occurred.

Discovery is the process after the filing of a lawsuit in which each lawyer seeks out information from the other side. They use the information to build their case and their plan of attack and to rebut their opponent's evidence. In the past, filing a motion to dismiss just meant that discovery would go on and the

motion would be ruled on prior to trial. This new section provides specific time limits within which the other side must complete discovery, and requires that the motion to dismiss be heard and ruled on by a judge within a matter of weeks rather than months or even years.

The motion to dismiss for noninvolvement is limited to those instances where a physician never saw the patient and perhaps didn't even render a consult. Or even if a consult was rendered, he or she didn't participate in that portion of the care which was allegedly negligent.

So again, we're hoping that accelerating the process will hold down costs, ease strain on the defendant, and encourage plaintiffs to be much more careful about who they sue. Perhaps we can end some of these horrendous shotgun lawsuits where everyone whose name appears anywhere in the medical chart is named as a defendant.

IMJ: *None of the provisions we've talked about so far—itemized verdicts, affidavit and consultant's report, counterclaims, and motion to dismiss—were included in the recent Supreme Court challenge. Can you discuss the challenged provisions?*

Saul Morse: Five provisions were challenged. I'll review them individually.

One section abolished punitive damages in medical and legal malpractice. Punitive damages are meant for punishment, not compensation. They are awarded when behavior is so horrendous that the court wants to send a message—both to the defendant and to others—that those who engage in this activity, will have to do more than just compensate.

Punitive damages are not insurable under Illinois law. You can't get insurance to cover them. That's part of why the Supreme Court challenge alleged that abolishing punitive damages had no relation to the malpractice insurance problem.

Here's what happens with a claim for punitive damages. For legal and ethical reasons, insurers are required to notify the insured that punitive damages are not covered, and that since there is a request for punitive damages, the insured may wish to hire his or her own private attorney at personal expense.



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The physician gets this notice and thinks, "My God, I don't have insurance for this. Is this going to take everything I've worked all my life to acquire?" He or she talks to their private attorney, who tells them, "The law in Illinois is that if you instruct your insurance company to settle the case within your policy limits, they have to do that. And if they settle it within your policy limits, then you won't personally be liable for the punitive damages." That's the case law on the insurer's obligation to its individual insured.

This applies to all insurance, not just malpractice. The theory behind it is that if you buy a contract of insurance, your insurer has an obligation to protect you. If you instruct your insurer to protect you by settling it within the policy limits and they don't, then they're guilty of bad faith. The extra money you may be held liable for under Illinois law has to be paid by your insurer. Not by you. Regardless of the reasons.

What was happening in Illinois was that punitive damages took the form of legal extortion. The way it worked was that the plaintiff's lawyer would request punitive damages, which are almost never awarded. This would create a situation in which the physician almost had to have two lawyers—his or her own and the lawyer from the insurance company.

Now his or her private lawyer would say, "I know you don't think you're liable, but they're requesting two million dollars in punitive damages. And since you may have to pay for that personally, it might be better to be protected and to tell your insurance company to settle."

If the insurance company is instructed to settle, they must at least make a good faith effort to do so—both because that's what they've been told to do, and because if they don't, they may be liable for the entire judgment. The bottom line is that the plaintiff has forced the physician to work against his or her insurer in helping to extort a judgment.

Abolition of punitive damages is important not because of the dollars involved, because there are very few cases in which they are awarded, but because doctors need relief from this "extortion" and because it's important to see that the decision to settle is based on the facts of the case. In those circumstances where the activity is so serious that the physician either should not be practicing or should have his or her practice examined and possibly limited, the appropriate "punishment" is action by the Medical Disciplinary Board.

We've been saying to the legislature for years, "If that's the situation, and if punitive damages are intended to protect the public, then shouldn't that doctor's license be examined and suspended or revoked? Doesn't that make more sense than giving one individual millions of dollars?" We have laws on the books to protect the public from the practitioner who is unqualified, dishonest, or unethical.

IMJ: *What about the change in the collateral source rule?*

Saul Morse: The collateral source changes were very important. The law in Illinois has always been that the jury cannot be told of the existence of any insurance. The reason for that is pretty sound. There's a sense that if jurors know there's insurance, the judgments will be higher because they'll think, "Well, somebody else is going to pay for this, so what's it matter?" Some of us think that happens to a fair extent already. But it would be worse.

The former collateral source situation meant that an individual who had, for example, health insurance could receive reimbursement for their medical expenses, could get disability income, Social Security payments and the like, then receive a second payment for the same things as a result of the judgment. It would result in double recovery.

The double recovery is one that everyone pays for. Because insurance—whether it's health insurance, homeowner's, automobile, or malpractice—is based on the concept of spreading the risk for one among the many. A double recovery not only compensates in excess of actual loss, but forces society at large to bear an added cost. I've been involved in malpractice reform for about eleven years—nine on behalf of the Society and two years before that working for the legislature. No one that I've met with in that entire period of time wanted to take fair compensation from an injured person. But if the goal of this kind of litigation is to compensate, then that's what it ought to do. It shouldn't do more than that.

The collateral source section was very carefully worded to provide that if the plaintiff is already obligated to repay somebody else, the verdict is not reduced. This point has been missed in the press and by the opponents of the legislation. We're really not just looking to cut down what we have to pay out. We're looking to avoid double recovery, even in instances where another insurer or employer or third party payor gets the money back.

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We've had a collateral source statute in Illinois for 10 years now. It was passed in 1976 and provided for a 50% reduction. This new section provides a 100% reduction for collateral source payments. The only exceptions are disability income and Social Security payments, which are reduced by 50%.

The new law also provides that any insurance premiums an individual plaintiff has paid in order to get these benefits in the first place are paid back. In other words, the verdict is not reduced by that amount. We didn't want the plaintiff to pay more than he or she would have had to pay just because this was a medical malpractice case. So we provided that they would be reimbursed by an amount equal to the last two years' premium payments.

IMJ: *Why are Social Security payments treated differently?*

Saul Morse: The reason for a 50% setoff rather than a 100% setoff was a very strong legislative sentiment that Social Security and veterans' benefits are in a different category.

Those are not the kinds of things the intelligent consumer goes out and gets to protect himself. They're not meant to provide for emergency medical expenses. They're intended to provide for the day-to-day care and upbringing of your family, to provide for your home, to put food on the table. There was a strong sentiment that those kinds of awards should not be touched.

Social Security, unlike health insurance, is not optional. Everybody has to pay into it. There's absolutely no choice—it's set by law as to how much you pay and when you pay. The legislature was not ready to force a full reduction for some negligent defendant. So that was modified to a 50% reduction.

The same people who felt that way in the legislature said, "Look, if you're going to cut a verdict by the collateral sources, is it fair to cut the verdict by what the physician or hospital charged for the negligent activity?" So the bill provides that charges which were rendered for the activity proven to be negligent cannot be reduced.

Let's take the example that there's proven negligence in a surgical procedure for which the physician charged $1,000. The legislature said that if that charge was for something proven to be negligent, then it shouldn't be reduced. That physician who was negligent shouldn't get paid for doing negligent work. We were more than ready to agree on that. Again, we're not looking to benefit negligent defendants. We're looking to avoid the kind of double recovery which exacerbates the problem and makes everybody in society pay.

IMJ: *That leads us to contingency fees.*

Saul Morse: That item was hotly debated. Lawyers who deal with contingency awards call them the poor person's key to the courthouse. They place legal representation within the reach of people who couldn't ordinarily afford it. And I have to tell you that although I don't personally like the contingency fee system, I can understand the rationale. Anyone who is truly hurt ought to have some way to get to court. As a practical matter, with the way lawyers charge, many people couldn't do it without contingency fee arrangements.

By the same token, the contingency fee system is seen by defendants and the like as though the lawyer is a salesman on commission. Because they're getting a percentage, they have an interest in pushing the case beyond what may be appropriate—pushing for more money than the plaintiff wants or needs. Because of that, many feel it's a system that creates litigation and inflates awards. The jurors say, "Well, look the lawyer's got to get paid somehow and we want to make sure this poor injured person is compensated. We have to give them more than they're really entitled to in order to make sure that the injured person is compensated."

The contingency fee system is outlawed in most other parts of the world. They don't have it in Canada. They don't have it in England. It's not in existence in most of Europe. It's really an American creation that goes with our frontier, gunslinger psychology, "Let's get in there and take a chance on something."

But the contingency fee system has a more serious problem for me, and that is that it's really just another insurance mechanism. In most contingency fee agreements the attorney says, "If I'm successful for you, I get a third of whatever you get. If I'm not successful, I get nothing. It doesn't matter if I spend two weeks or two years on it. There's a chance that I'll ask for a million dollars, make a phone call and get my million dollars for you. And by working five or ten minutes, I've earned over $300,000. There's another chance that I'll have to put in hundreds and hundreds of hours of work to win that. That's the risk that I, as the lawyer, am willing to take for you. And it tells you that no matter how much I do, you know in advance what I'll charge you."



We have laws on the books to protect the public from the practitioner who is unqualified, dishonest, or unethical.

But if you examine it more closely, what it really means is that the lawyer is saying, "Look, I'm going to win some of these cases and I'm going to lose some of these cases. I'm not going to collect in every case—especially in medical malpractice." The attorney knows that something like 80% of malpractice

claims result in no payout whatsoever to the patient, and of those cases that actually go to trial, three out of every four result in a judgment for the doctor.

The lawyers in all of those cases that result in no payment to their plaintiff essentially do that work for free. It becomes an insurance mechanism in the sense that the 20% who show they're really injured and get some kind of payout are paying to make it possible for the 80% to have a lawyer for free. One reason to limit the contingency fee is that while it may be a key to the courthouse for the poor man in some respects, it also spreads the risk for losing a case among all plaintiffs, so that those plaintiffs who are truly injured pay for those who have either a frivolous or a questionable case.

Not every action that a physician wins is a clear-cut frivolous case. There are cases of honest disagreement and there are cases which may or may not be negligent. So it's not as though everyone who loses is frivolous.

But the point, again, is a question of equity. Should those who are truly injured pay a surcharge so that those who are not can have a lawyer for free?

Those who supported limiting the contingency fee felt that it shouldn't be used as an insurance mechanism. They also believed that if you're truly injured, you need that money, and there should be some guarantee that you will get a certain percentage of it. Some lawyers have allegedly charged as much as 40% in some instances. I've heard stories, although I don't know if they're true, that some have even charged 50%. Now that's not the norm within the legal profession. A very small percentage of lawyers work on a contingency basis, and the overwhelming majority of them work on the basis of one-third. The contingency fee limitation is an attempt to guarantee that the injured party really gets the overwhelming majority of that judgment. Because if they're injured, they need it. They're entitled to it.

IMJ: *Structured verdicts are among the more complicated of the new provisions. What will be their practical impact?*

Saul Morse: Structured verdicts are terribly important from an economic perspective. The structured verdict law applies to any malpractice case in which either side requests it and future damages exceed $250,000. The new law stipulates that payments for future damages must be made over the lifetime of the plaintiff.

First of all, notice that it applies only to future damages. Past damages get paid right away because they've already been incurred. Those could include hospital and medical charges, rehabilitation and any other kinds of expenses the plaintiff has already incurred. They could include a few years' earning capacity, because by the time some of these cases get to trial, the plaintiff may have been out of work for quite some time.

Illinois law formerly held that future damages would be paid right away in a lump sum. Now that creates several situations. The jury has been instructed to take the amount of the damages and reduce it to present cash value. It's the "one bird in the hand versus two in the bush" theory. Money you have today you can invest. You'll earn interest on it. Over time, it will yield the full amount of what you needed. Verdicts are reduced to present cash value to avoid unjust enrichment.

To be candid, the problem is that reducing to present cash value is such a complicated process that most lawyers and judges don't fully understand how to do it. For example, say we have a hypothetical case in which future inflation is estimated at trial to be six percent per year. This particular plaintiff can expect merit raises of maybe another one or two percent every three or four years. Additionally, there will be increases in productivity worth a certain sum. The actuarial tables indicate a work life of 30 years and an actual life of another 50 or 60 years.

And I have to tell you that although I don't personally like the contingency fee system, I can understand the rationale. Anyone who is truly hurt ought to have some way to get to court.

So you take the damages and you take present income and you multiply it all out. After you've done all of that, you are charged with the responsibility of saying what that amount of money is worth today. What you have to do is discount it. You're given evidence by economic experts and statisticians and actuaries which says that you can discount at three, four, five, seven, eight percent per year to account for inflation and compound interest and all the other factors that make money grow. So you take it all back to its current cash value.

That's just incredibly difficult and complex. Yet we expect twelve people, some of whom may be very sophisticated, some of whom may be experienced in this area, some of whom may not have any sense of this whatsoever, to do something which economic experts and statisticians spend years learning. It's very difficult to be a juror, it really is.

There are many people, myself among them, who honestly believe that jurors do not reduce to current cash value. There's no way for us to know whether they really have done it or not. The structured verdict bill, first of all, says that the jurors are not supposed to do that.

They're supposed to take the evidence that is given to them and just come back and say to the court, "This is the total dollar value of the compensation that we think this plaintiff deserves." Then the judge reduces it to present cash value.

We think that's important for several reasons. First, we'll have one individual educated and trained to do this. The judges involved handle malpractice cases repeatedly. We think that will give us consistency, in that plaintiffs with similar injuries will be treated in the same way. Consistency means that we'll know better what to expect, which makes it easier to determine an appropriate settlement when that's what's called for. It will also make it easier to know when it might be appropriate to appeal a case because the damages are unrealistic. And it makes it easier, ultimately, for insurers to put a price on a malpractice insurance policy. It's very difficult to price these things. We're hoping that structured verdicts will lend fairness and consistency. It will take a period of years but we're hoping that it will give us and our individual physician members some sense of what to expect.

Structured verdicts have other advantages. By providing that annual payments come to the plaintiff over his or her actuarially determined life, we anticipate that it will cost less to pay for these judgments. It's the same, "one bird in the hand versus two in the bush," principle at work. If you have to pay out two million dollars right away, that costs two million dollars in 1986. If you have to pay $100,000 per year for 20 years, it still costs two million dollars. But by permitting insurers to know when they'll have to pay it, enabling them to plan for it, and not forcing it all in one year, it's less costly.

IMJ: *And it reinforces the fact that this system is intended to provide compensation.*

Saul Morse: It does more than that. It says that the compensation will be there for you, injured plaintiff, at the time the jury has found that you'll need it.

One of the problems that we have found—and it certainly doesn't apply in every case—is that some plaintiffs just don't know how to handle money. It's really impossible for me to tell you how often, but it does happen. Some of these people spend all the money right away. Some of them fall prey to poor financial advice. They don't use it for the purpose intended.

These people, who have been injured through no fault or little fault of their own, are out there unable to fend for themselves and care for themselves. Who supports them? All of us.

If somebody has been negligent, that person ought to pay. Not all of society. I think it's a societal benefit to stagger the payments so that, to the greatest possible extent, the negligent party compensates the injured person. It benefits the injured person and it benefits society.

Some people have said that you're abrogating the plaintiff's freedom. That we should be saying to the individual plaintiff, "Here's the million dollars you're entitled to. Hold it in your hands." That now they're losing their right to control it. That's nonsense, because while some of them could perhaps invest it and make more money, most of them couldn't. If jurors really reduced to present cash value, two things would have to happen before the plaintiff could get what the jury really thought they were entitled to receive. All the jurors' assumptions would have to be correct, and they would have to have good financial advice and invest it properly.

It's not as if giving it to them right in their hand results in their having that amount of money. They only have that amount that the jury thinks they need if they properly invest it. What we're saying is that you are going to get what the jury said. The difference is that instead of your investing it, it's going to be invested and returned to you. So the plaintiffs aren't getting any less under this than they got before. That's absolute nonsense. Some people have said this acts like a cap on awards because it takes away from the plaintiff monies that they've proven they're entitled to. It does no such thing. Not at all.

The court retains jurisdiction to make sure the defendant is paying. Let's say the defendant buys an annuity from a company that later goes bankrupt. The court at that point could order the defendant to come in and pay the balance on the spot. The plaintiff is protected. The court can decide if the payment method is adequate. If it's not, the court can order payments right away.

Structured verdicts will take time to work. They're very involved and detailed. But anything that deals with finances over a long period of time has to be. It won't happen tomorrow, but I think that if we give it enough time, structured ver-

One reason to limit the contingency fee is that while it may be a key to the courthouse for the poor man in some respects, it also spreads the risk for losing a case among all plaintiffs, so that those plaintiffs who are truly injured pay for those who have either a frivolous or a questionable case.

dicts will be a truly revolutionary benefit to injured plaintiffs. And they're going to give us some stability in funding malpractice judgments.

IMJ: *How about the one section that the Supreme Court struck? What happened with screening panels?*

Saul Morse: Some history might be enlightening on that subject. In 1975, legislation was passed to create screening panels made up of a judge, a lawyer and a doctor to hear cases. That legislation was challenged and, in 1976, the Supreme Court struck the provision for screening panels.

In 1976, the court said, "Look, when you take away somebody's right to trial by jury, which is recognized in the Constitution, you have to do two things."

"First, you have to do it on a rational basis. Apply it to everybody in the same class of people, so nobody in a similar class is treated differently." That's the equal protection theory—that everybody similarly situated should be treated in a similar fashion. In '76, by a five-to-two majority, the court said that since this applies only to plaintiffs who are injured by physicians and not those injured by other people, it denies equal protection. Two people might have the same injury and the same circumstances but if it's the result of a car accident, they go right to trial while if it's the result of malpractice, they have to go before this panel. The panel may be more time consuming and more expensive. That's a denial of equal protection. We dealt with the equal protection objection in 1985 by stipulating that the provisions would apply equally to both defendants and plaintiffs in all health care cases.

The second thing the court said was that the legislature should show good cause to take away somebody's right to trial by jury. There's got to be a *quid pro quo.* There has to be a trade-off to make it fair and equal. You must give this for that. Everyone has the right to due process before the courts.

The best example of that in Illinois law is workers' compensation. In workers' compensation, injured workers gave up their right to go to the courts for an injury. In return, the employers gave up their right to challenge the workers' entitlement to compensation. In some respects, it's like a no fault system.



With medical malpractice screening panels, the injured party or the allegedly injured party gave up the right to go directly into trial court. But the defendant physician didn't give up anything. He could still challenge and fight the complaint on every point. The court found no fair and equal trade-off.

We dealt with the due process objection in 1985 by ensuring that anyone who so chose could go on to trial without penalty. The only risk—that the party which had lost by a unanimous screening panel decision would be liable for the other party's costs if they again lost at trial—was equally shared by both parties.

We knew that section was the most vulnerable to an attack on constitutional grounds. We thought it important to try again. Because in 1979, the Supreme Court clarified their position. They said that in striking down the '75 screening panels, they hadn't meant to say that there was no way you could ever have a screening panel. In fact, the Illinois Supreme Court was so roundly criticized all over the country for what it had done in 1975 that it went to the trouble to reiterate and explain its reasoning four years later.

So we thought that screening panels were something we could address with a new approach. The screening panel legislation was passed in '85, largely, I think, because of the perception that the jury system wasn't working and something needed to be done. And that something was a way to weed out the non-meritorious cases in some setting or tribunal which didn't have all the problems of the current jury system. The screening panel bill was a good faith attempt to address two problems: frivolous cases and a system that did not seem to be working.

The court struck it for a number of reasons. The specific reason select-

But the point, again, is a question of equity. Should those who are truly injured pay a surcharge so that those who are not can have a lawyer for free? Those who supported limiting the contingency fee felt that it shouldn't be used as an insurance mechanism. They also believed that if you're truly injured, you need that money, and there should be some guarantee that you will get a certain percentage of it.

ed by the five-member majority in 1976 was that when a trial judge sits on a screening panel, his or her duties are diluted. They have to share their power with the two lay people. We attempted to address that in 1985 by providing that the judge, alone, would decide questions of law, and the panel, as a whole, would decide questions of fact.

convicted of murder, a three judge panel would determine whether that person would get the death penalty.

The Illinois Supreme Court said in 1976, "You can't have a three judge panel because our Constitution says that we have a circuit, an appellate, and a supreme court. It doesn't say we have some other court com-



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In the courts, the judge is the finder of law and the jury is the finder of fact. Those are their two functions, and they can't trample on each other's functions. We thought we had addressed that.

But the Court came back and said that having the judge determine all legal questions was fine, as far as it went. But making the judge part of the panel that found the facts did one of two things. It either forced the judge to assume the position of juror, which was not his or her constitutional role, or permitted non-judges—the lawyer and doctor on the panel—to assume judicial powers, which was not permissible. Our Constitution defines very precisely what a judge may or may not do, and who a judge may be. The court found that mixing the judge's role made our screening panels unconstitutional.

It's important for people to understand that decisions on screening panels are based—at least to some extent—on other decisions which don't relate to medical malpractice. Our Court in Illinois has been fairly consistent on this point. In 1976, after the U.S. Supreme Court had stricken the death penalty, the Illinois legislature passed a death penalty statute. That '76 statute provided that after an individual was

posed of three judges. So the legislature couldn't create a new court. Did that make this new body another circuit court?

They said that a three judge panel couldn't work because if it's a circuit court, then it's one in which a judge is required to share his or her duties with two other judges. And the legislature can't dilute a judge's power because they are separate and equal branches of government. Neither can control the other. So they threw out a three judge mechanism in the death penalty context out of concern about diluting judicial power.

In January of 1983, the Court came down with another decision that relates to this. That dealt with the last Stevenson-Thompson election, in which there was a statute providing that statewide election recounts would be handled by a three judge panel appointed by the Supreme Court. I was very involved in that because I was one of Governor Thompson's lawyers in the case.

The Supreme Court said again, that you can't have three judge panels. You can't dilute the power of a judge. That's the key point. A judge acts independently and a judge makes decisions. Judges don't share power under our Constitution.

That's what the majority found wrong in our screening panels. They didn't go any further because courts generally only do that which they think they need to do. If they find that a law's invalid for one reason, they don't need to address every other concern.

People should understand that we really got a unanimous decision on the points upheld, which is very significant. In the one dissent, Justice Ryan said that he would have upheld structured verdicts, punitive damages, contingency fee limitations and collateral sources. He agreed with the majority. We really got an unanimous decision on those points.

But Justice Ryan said that he would have upheld the screening panels also. He saw a genuine attempt to ensure that the judge handled the legal functions. He felt that we had responded to the court's 1976 objections, effectively isolated that power and restricted it to the judge. He said that he would have upheld on that aspect but would have wanted to address the *quid pro quo* issue, which the '76 court had dealt with but the current court really hadn't addressed.

Justice Ryan's minority opinion indicated that he would have strick-

en the provision providing that individuals who lost by a unanimous determination of the panel had to pay the other side's attorneys' fees if they went on to lose at trial. He would have upheld screening panels with that change, because the *quid pro quo* would have been satisfied. The screening panels would not have really limited anyone's right to get into court. There would have been an extra step, but they wouldn't have run any risks if they had gone on to trial. If you don't run any risks, then it's not a limitation.

The very real problem is that screening panels are useful only if they provide a mechanism to deter plaintiffs from taking frivolous cases to trial. The provision that would have shifted fees was essential. That provision would have said, "You don't go to trial. You don't go to court. You don't incur all these extra costs and charges. And if you do and if you still lose, then you have to pay the other side."

Without that deterrent, screening panels would just become a way to show each side the other's evidence and provide an opportunity to get around it or find new evidence before trial. Everybody would incur the extra expense of this second procedure. That extra expense is worthwhile if the process keeps frivolous cases out of court. And it would have also applied to defendants losing by a unanimous determination and continuing to trial.

If we don't have that mechanism to stop cases, then screening panels simply expose the evidence early and at significant extra cost. We still have to pay the attorneys and expert witnesses.

We could probably deal with what the majority said in the opinion if we were to try for screening panels again. But it would be very, very difficult to deal with what Justice Ryan said and we don't know whether the majority members share his concerns. If you look at all of the Supreme Court decisions over the last ten years on this issue, I think they do. It's logical that they would. It's consistent with what they've been saying in malpractice and in other areas. It's a question of the court's power to handle its duties. And that is the only section of the new law that wasn't upheld.

IMJ: *The trial court struck five provisions of the Medical Malpractice Act of 1985 but the Illinois Supreme Court upheld four of those items on appeal. We know that this was a terrific political victory. Is it a significant legal precedent?*

Saul Morse: It's very significant because it's a real reversal of the decisions coming from the courts in the '70s. It's also significant because of Judge Wosik's strong decision, throwing everything out at the circuit court level. And it's significant because all six participating justices agreed about the four provisions that were upheld. I consider it unanimous on those points. Very strong. That sends a message to plaintiffs, plaintiffs' lawyers, and to the circuit and appellate courts of the state.

As we're talking today, a petition to reconsider the decision has been filed by the plaintiffs. It asks that the court take another look at structured verdicts. We don't know what will happen with that. But the court, having so recently decided such a significant case, would have to have strong concerns in order to hear it again. Especially when the decision was unanimous on that point and four justices would have to vote to reconsider. That action has been filed and is pending. It's the only point that was questioned, which indicates that it's a real concern among plaintiff lawyers.

IMJ: *It's been said that the new reforms, in conjunction with appropriate use of the motion for summary judgment, may be able to fulfill the intent of the screening panels. Do you agree?*

Saul Morse: That may prove to be true. First, I think, it's important to understand that many physicians feel the jury system doesn't deal appropriately with medical issues and responsibilities That's part of the rationale behind screening panels.

Our court system suffers from a lack of credibility right now, not only among physicians but among other citizens as well. The support for screening panels was based, at least in part, on a perception that our court system just doesn't work.

We have a number of new tools. These may, at the very least, do some of the things screenings panels do and might deal with the problem adequately.

Let's look at what we've got to weed out frivolous cases. We have a section of the law requiring that every case have an affidavit and a qualified consultant's report which stipulates the theory of the alleged negligence. That will weed out some cases, because plaintiffs just won't be able to get that report. In other cases, the report may be so speculative that it allows a motion to dismiss or a motion for summary judgment. These are legal terms for actions which ask the court to refuse to hear a case because, even in the best possible light, the plaintiff doesn't have a basis for it. Ulti-

If somebody has been negligent, that person ought to pay. Not all of society. I think it's a societal benefit to stagger the payments so that, to the greatest possible extent, the negligent party compensates the injured person.

mately, lawyers and plaintiffs will begin to see that those cases are not going to result in a fishing expedition for facts or a quick settlement, and they won't be filed. It should mean big savings in money and in lawsuits.

don't take cases that don't look to be valid and meritorious. You look at a lawyer like Phil Corboy who, up until 1985, had not lost a jury trial in 17 years. You can't say that's just because juries don't know what they're doing.

Our Constitution defines very precisely what a judge may or may not do, and who a judge may be. The court found that mixing the judge's role made our screening panels unconstitutional.

IMJ: *It's been said that we may have problems in working through the expert witness affidavit provision, that we may experience delays for* in camera *examinations to verify credentials. Are you concerned about that?*

Saul Morse: I have a concern about that, but I also have a way to deal with it. We'll be keeping the defense attorneys abreast of changes in the law. We'll be available to act as assistants for them to explain what the legislature did and why. One of our concerns is that the consulting report attached to the complaint is to be anonymous.

The affidavit of noninvolvement will take care of some cases. These changes to the law on untrue allegations state that a person making untrue allegations, or his lawyer, may have to pay the other side's legal fees. It may tighten the way these cases are handled. It should cut down on shotgun lawsuits, where multiple defendants are named just because their name appears on the chart, or they're on the hospital staff.

The counterclaims provision may deter some plaintiffs. This tells the plaintiff, "If you go to trial, and you lose, and it can be shown that your case was brought willfully or wantonly without any real basis, the physician may sue you for his or her fees and expenses."

All of those things and the other provisions in the law will say to people, "Look, we've got to be very careful. We've got to file really good solid cases." That may mean that fewer lawyers will be willing to take malpractice cases. We'll see more and more specialists.

So the firms which only take the good cases may start getting more and more referrals because the average lawyer may not be willing to run the risk that this law has created. That's not necessarily bad. If the purpose of the screening panels was to weed out frivolous cases, we've got some provisions that will do it.

Another problem is the nuisance lawsuit, the small dollar action, which is very frustrating. The collateral source legislation may eliminate those cases. If your damages are reduced by your collateral sources, you don't have permanent disability, and you're not restricted in your daily activities, a lawyer may look at you and say, "Gee, you've got a great case, but the legislature said you can't get double recovery. The chances of your collecting are slim." That will have an effect on the filing of cases.



People should understand that we really got a unanimous decision on the points upheld, which is very significant.

From day one, some of the best-known plaintiff lawyers around the state were very actively involved in opposing this legislation. And frankly, when you get right down to the bottom line, it always struck me that we were doing these people a big favor. These are good lawyers. They lose some cases. They're difficult to deal with at times. But they

So, in answer to your question, yes, I think it is possible that we'll get what we wanted from screening panels through other sections of the new law.

Let's take a bizarre hypothetical. Say we have an anesthesiologist charged with negligence, and a consultant's report is rendered, but the consultant is a dermatologist. In order for that consultant's report to comply with the law, that consultant must be qualified to render an opinion on the quality of care given by the defendant physician. The law

requires that persons presented as experts or witnesses be qualified. If a consultant's report appears far from reasonable, then our defense lawyer can move to dismiss the complaint on the basis that the consultant's report doesn't comply with statutory requirements. He or she can ask the trial judge for a confidential review of the consultant's qualifications. The judge can then determine whether the witness is qualified to offer an opinion as to the defendant physician's level of care and competence. Our defense lawyers will be prepared to do that.

Fundamental changes in a system which has taken years to get where it is today require vigilance and work over time. Revolution comes very, very slowly to the law. There are no miracle drugs.

The law is a body of thought which evolves gradually from common sense application of rules to problems. We have new tools now. We have new weapons. The new law will have to be applied to individual cases. We'll have to see how it fits into situations anywhere from the family practitioner with limited support resources in a small community hospital to a subspecialist performing the most complex procedure at the biggest teaching institution in the state. And as we fit the law into those individual situations, we'll learn how it works.

The law must be applied consistently. We want to send a message to lawyers and to judges and ultimately, to patients and plaintiffs: these are the rules. That's part of the reason for some of the technical provisions. Itemized verdicts and pleading rules are mechanisms to establish a statewide standard. We want evidence that gives us data. We want judges producing the present cash value rather than juries. In many counties, the same judge hears all the malpractice cases. Whether they're good, bad or indifferent, we'll get consistency. We don't have that right now. It's terribly important. And that does not happen overnight.

IMJ: *How do you expect to see the new law challenged?*

Saul Morse: We're not out of the woods yet on constitutional challenges. We won the major one, but several sections of the law have not been challenged in court at all. To me, this says that some of the best trial lawyers in the state must have made a judgment call that those sections probably would not be struck. That doesn't mean that some other trial lawyer somewhere won't bring a successful case. It just means that some of the people perceived to be among the best minds in that profession thought they would stand.

The affidavit and consultant's report attached to the complaint weren't challenged. The reinforced requirement for payment of attorneys' fees when there are untrue allegations in a pleading hasn't been challenged. The counterclaim section hasn't been challenged. The itemized verdicts—I think those are strong. But that doesn't mean they won't be challenged.

We don't know what will happen if someone brings a lawsuit under structured verdicts, for example, and says, "This violates my constitutional rights. I have an injury that resulted in $251,000 in future damages that has to be structured over my actuarial life. I may not get to see it all because I may die before the end of my actuarial lifetime. And somebody down the street has a similar injury worth $249,000 in future damages which doesn't have to be structured. If we have the exact same injury and the only difference between us is that I'm an $18,000 a year school teacher and my neighbor is an $80,000 a year executive, is that fair?"

I think that we will prevail. But I also think that we will have that case. I think it will come.

It's difficult to draft laws that apply to 11.5 million people fairly and equally. It's analogous to the way in which some courses of treatment react differently in different people.

IMJ: *What kinds of test cases might we see?*

Saul Morse: Let's take a situation where we have an injured baby. The statute of limitations extends until majority, which in some instances can be at least 22 years.

Fundamental changes in a system which has taken years to get where it is today require vigilance and work over time. Revolution comes very, very slowly to the law. There are no miracle drugs.

A number of people may be involved in a difficult delivery. The hospital and its nursing staff. The anesthesiologist, if there is a local or general anesthetic. The obstetrician. The pediatrician who sees the baby immediately after birth.

I can see a situation in which a good trial lawyer might get a consultant's report from someone as to one doctor. He or she either can't get one as to the other doctors, or hasn't tried. They file a lawsuit naming just that one doctor. Ordinarily, you would name everyone involved to try to find out who did what and to apportion the responsibility. More often than not, no one person is fully responsible for everything. At any rate, the lawsuit is filed against one physician. Proceding with the lawsuit, we face several, very interesting and troublesome circumstances. One is that they file a lawsuit against one physician and

go through discovery to find out who did what. The basis for their next case against the other physicians and hospital is a product of evidence produced in the first trial. When they file suit against the others, they know they've got a good affidavit attached to it and they know they've got a good case. Remember, they have 22 years to explore all the options.

Here's another possibility. They file against the obstetrician only. The obstetrician meets with the defense lawyer right after the case is filed. And in sitting down with the defense lawyer and going over notes and recollections, he says, "Well, look, the nurses in the delivery room failed to do this. I had told them to do that. I left instructions that they didn't follow. Or they didn't follow normal operating procedure." The defendant physician feels that other members of the team should bear some of the responsibility. The anesthesiologist, or the hospital. Maybe the equipment didn't function or wasn't there. We face a situation where the individual defendant physician may say, "Why can't you bring them into this lawsuit? They're really just as responsible or more responsible than I." So we may have some physician-induced litigation against other physicians.

People have to understand that all of this could have happened under the old law. These are not new monsters. The plaintiff could have sued anyone tangentially involved at any point in time. Now, though, there may be more of these suits. The stakes have been redefined. As we experiment with this law and apply it to specific situations, we will have to monitor its evolution and we'll have to be very vigilant. These are issues which must be approached with consistency.

We have hundreds of lawyers around this state doing defense work. Each one has his or her theories and methods. Some work well and some not so well. Each one of them knows their individual judges and their juries and what to expect. That's terribly important. But by the same token, there are some broad policy concerns and strategic issues that mandate coordination if this law is to do what we want it to do. There's a long road before us both judicially and legislatively. There are items which must yet go before the legislature. And there are interpretations yet to be rendered and weighed.

Editor's Note: Our November issue will feature the balance of this interview, focusing on an agenda for future action. ◂

Implementing the New Law

The Medical Malpractice Reform Act of 1985 encompassed a series of sweeping changes in tort law. Their impact will be defined as judges across the state make pertinent rulings on cases before them.

Circuit, associate and supreme court justices will have an opportunity to study and evaluate the malpractice reforms at the annual Illinois Judicial Conference this month, a mandatory educational meeting for Illinois justices. Medical malpractice will be one of five seminar sections this year.

Cook County Circuit Court Judge Edwin M. Berman is chairman of that section. He was also responsible, under Chief Circuit Court Judge Harry G. Comerford, for tentative preparations to implement malpractice screening panels. Those plans will not be carried out, as the Supreme Court's decision struck screening panels from the new Act. This was a disappointment, but as Judge Berman pointed out in a recent interview, other mechanisms exist to help keep frivolous suits out of the courts.

"You have a right to file for summary judgment," Judge Berman said. "Summary judgment occurs before trial with affidavits and testimony under oath. And if a court feels that there is no viable case, judgment is granted right then and there. That's better than a panel hearing because it's final."

The provision requiring that an affidavit and consultant's report be attached to malpractice complaints should also be helpful. Judge Berman cautioned, however, that it might require refinement, as the current law does not require that the expert witness be identified or that his or her qualifications be specified.

"I expect that a lot of defendants will test the qualifications of the person who says there is a case," he said. "We'll have *in camera* inspections to see that there really was a doctor in that discipline who said that, without revealing his or her identity."

The courts will grapple with administrative issues in several areas. "We have to take up the question of how the jury is to be informed," he said. "Is it before they go in to deliberate? Or do we remove the amounts afterwards? We'll see how other states have handled it and get a little indication of what the prevailing thought is."

Judge Berman called upon employers to see that their personnel are available for jury duty. Those who seek a jury of their peers should support the jury system, he said. Employees who can be spared should not be given employer exemptions.

"We're trying to do things," he concluded. "We're trying to implement a more expeditious way of getting to these cases. The system's there. The jury trial's there. That's our system. Both sides must handle their cases expeditiously and bring them before the courts." ◂

(continued from page 112)

Diagnosis: Acquired Immunodeficiency Syndrome

The patient's age and symptoms make alveolar cell carcinoma unlikely. Allergic alveolitis could cause episodic symptoms and diffuse lung changes but would not be related to *Candida* infections. This patient did have a *Pneumocystis carinii* lung infection, so this would be a good choice. The best choice, however, is the acquired immunodeficiency syndrome (AIDS). The immunodeficiency accounts for the lung infections and the *Candida* infections. In this patient, it was hypothesized that AIDS had been transmitted by the blood transfusions.

AIDS Etiology

The agent implicated as the cause of the acquired immunodeficiency syndrome (AIDS) is the human T-cell leukemia virus III (HTLV-III).[1] AIDS is found predominately in homosexual and bisexual men, intravenous drug abusers, Haitians living in the United States, hemophiliacs, heterosexual contacts of persons at increased risk for AIDS, and recipients of blood transfusions.[2] A small percentage of patients do not fit into any of these risk groups.

The first reports of AIDS were in 1981.[3,4] AIDS is characterized by defective cell-mediated immunity, notably lymphopenia, (total lymphocyte count less than 500/mm^3) altered helper/suppressor T-lymphocyte ratio, and decreased T-cell function (both *in vitro* and *in vivo*) for B-cell activation.[5]

Complications

The predominant clinical manifestations of these immunologic abnormalities are unusual neoplasms and a variety of opportunistic infections. Pulmonary involvement is a major source of morbidity and mortality.[3-5] The most common pulmonary complication is infection; *Pneumocystic carinii* pneumonia (PCP), *Mycobacterium avium-intracellular,* bacterial, and cytomegalovirus (CMV) pneumonias are the most common[6,7] (see Table 1).

Neoplasms also occur in these patients, including unusual forms of Kaposi's sarcoma,[8] oat cell carcinoma,[9] and pulmonary lymphoma (diffuse large cell immunoblastic).[6]

In addition, non-infectious, non-neoplastic forms of pulmonary diseases occur, including idiopathic pneumonitis,[10] lymphoid interstitial pneumonitis,[11] diffuse alveolar damage,[11,12] desquamative interstitial pneumonitis,[11] and mononuclear cell infiltrates.[7] Frequently, multiple pulmonary disease processes occur together, especially *Pneumocystis carinii* pneumonia plus *M. avium-intracellular* pneumonia,[6] *Pneumocystic carinii*

Table 1
Pulmonary Complications in AIDS

Infectious
Parasitic
Pneumocystis carinii
Cryptosporidium
Toxoplasma gondii
Viral
Cytomegalovirus
Herpes simplex virus
Fungal
Candida albicans
Cryptococcus neoformans
Histoplasma capsulatum
Aspergillus fumigatis
Coccidioides immitis
Bacterial
Mycobacterium tuberculosis
Mycobacterium avium/intracellulare
Mycobacterium kansasii
Hemophilis influenza
Streptococcus pneumoniae
Legionella pneumoniae
Clostridium innoccum (especially with ARDS)
Salmonella enteritidis (especially with ARDS)
Klebsiella pneumoniae
Pseudomonas aeroginosa
Mycoplasma pneumoniae
Neoplastic
Kaposi's sarcoma
oat cell carcinoma
Pulmonary lymphoma (diffuse large cell immunoblastic)
Burkitt's-like lymphoma
Non-Hodgkin's lymphoma
Non-Infectious, Non-Neoplastic
Lymphoid interstitial pneumonitis
Diffuse alveolar damage
Interstitial fibrosis
Desquamative interstitial pneumonitis
Non-specific pneumonitis
Bronchospastic disorder
Pulmonary hemorrhage
Mononuclear cell infiltrates
Pleural
Thickening
Effusion

and CMV pneumonias.[6] Kaposi's sarcoma may occur along with infectious pneumonia.[13]

Clinical

Clinical presentation of pulmonary disease in AIDS patients varies from insidious to acute. Frequent symptoms include cough and dyspnea. Less common symptoms are sputum production, pleuritic pain and hemoptysis.[7] Frequent signs are fever and tachypnea.[7] Patients with *M. avium-intracellular* are usually asymptomatic unless another pulmonary process is present.[7] Bacterial pneumonias most often present with an acute onset of respiratory symptoms.[7]

Radiology

Radiographic findings include interstitial and alveolar infiltrates, (diffuse, segmental, or lobar) interstitial nodular densities, pleural effusion, abscess, adenopathy, and also completely normal chest x-rays. While classical patterns of pulmonary pathology are sometimes found, radiographic findings are more often atypical and are not characteristic for specific infections, tumors or any particular non-infectious, non-neoplastic process.[2,7,13-15]

The gallium scan is a sensitive but non-specific test for *Pneumocystis carinii* pneumonia, particularly in the early stages, when radiographic findings are normal or equivocal. It is especially useful as a guide to early bronchoscopic or open lung biopsy.[2,16]

Pulmonary Function Studies

Pulmonary function tests are frequently abnormal in AIDS patients with pulmonary complications. Again, however, the abnormalities are not specific. Diffusing capacity is a sensitive indicator of pulmonary disease in general. It has been found to be significantly lower for AIDS patients with PCP or Kaposi's sarcoma than for patients with CMV or non-specific pneumonitis.[17] However, there are reports of patients with PCP and normal diffusing capacity.[17]

Resting alveolar-arterial oxygen tension differences do not appear to be useful in determining or distinguishing disease. However, exertional alveolar-arterial oxygen tension difference is markedly increased in patients with PCP.[7,12] In other diseases the difference is variable. Also reported in PCP are reduced vital capacity and increase expiratory flow rates (FEV/FVC).[2]

Arterial blood gas analysis is useful in monitoring severity of pulmonary involvement. Hypoxemia is commonly found. Hypocarbia may also be seen.[2]

Diagnosis

Definitive diagnosis of pulmonary disease in patients with AIDS may rarely be accomplished with sputum sampling. However, bronchoalveolar lavage (BAL), transbronchial-lung biopsy and/or lung biopsy are usually necessary.[2,18]

Treatment and Prognosis

Treatment of pulmonary complications in AIDS patients depends on the diagnosis. Some infections can be treated, although recurrence is frequent. Neoplastic processes are treated with chemotherapy or radiation therapy in some instances. Despite short-term effectiveness of therapy, prognosis remains poor. Patients with opportunistic infections have a median survival of 6.4 months and a mortality rate of almost 100% by one year. Patients with Kaposi's sarcoma have a median survival of 16.7 months with an approximate mortality rate of 75% by 2 years.[6] The magnitude of the problem is apparent when considering that the Centers for Disease Control had been notified of 16,458 patients with AIDS as of January 13, 1986.[19]

References

1. Marx, J.L.: "Strong New Candidate for AIDS Agent. A Newly Discovered Member of the Human T-cell Leukemia Virus Family Is Very Closely Linked to the Immunodeficiency Disease," *Science* 224:475-477, 1984.
2. Hopewell, P.C., Luce, J.M.: "Pulmonary Involvement in the Acquired Immunodeficiency Syndrome," *Chest* 87:104-112, 1985.
3. Centers for Disease Control: "*Pneumocystis* Pneumonia: Los Angeles," *MMWR* 30:250-252, 1981.
4. Centers for Disease Control: Kaposi's Sarcoma and *Pneumocystis* Pneumonia Among Homosexual Men: New York and California," *MMWR* 30:305-308, 1981.
5. Fauci, A.S., Macher, A.M., Longo, D.L., *et al.*: "Acquired Immunodeficiency Syndrome: Epidemiologic, Clinical, Immunologic and Therapeutic Considerations," *Ann Intern Med* 100:92-106, 1984.
6. Marchevsky, A., Rosen, M.J., Chrystal, G.C., Kleinman, J.: "Pulmonary Complications of the Acquired Immunodeficiency Syndrome: A Clinicopathologic Study of 70 Cases," *Hum Pathol* 16:659-670, 1985.
7. Stover, D.E., White, D.A., Romano, P.A., *et al.*: "Spectrum of Pulmonary Diseases Associated with the Acquired Immunodeficiency Syndrome," *Am J Med* 78:429-437, 1985.
8. Ognibene, F.P., Steis, R.G., Macher, A.M. *et al.*: "Kaposi's Sarcoma Causing Pulmonary Infiltrates and Respiratory Failure in the Acquired Immunodeficiency Syndrome," *Ann Internal Med* 102:471-475, 1985.
9. Moser, R.J., Tenholder, M.F., Ridenour, R.: "Oat-cell Carcinoma in Transfusion-Associated Acquired Immunodeficiency Syndrome," *Ann Intern Med* 103:478, 1985.
10. Fanta, C.H., Pennington, J.E.: "Fever and New Lung Infiltrates in the Immunocompromised Host," *Clin Chest Med* 2:19-39, 1981.
11. Joshi, V.V., Oleske, J.M., Minnefor, A.B., *et al.*: "Pathologic Pulmonary Findings in Children with the Acquired Immunodeficiency Syndrome: A Study of Ten Cases," *Hum Pathol* 16:241-246, 1985.
12. Ramaswamy, G., Jagadha, V., Tchertkoff, V.: "Diffuse Alveolar Damage and Interstitial Fibrosis in Acquired Immunodeficiency Syndrome Patients without Concurrent Pulmonary Infection," *Arch Pathol Lab Med* 109:408-412, 1985.
13. Murray, J.F., Felton, C.P., Garay, S.M.: "Pulmonary Complications of the Acquired Immunodeficiency Syndrome: A Report of a National Heart, Lung and Blood Institute Workshop," *N Engl J Med* 310:1682-1688, 1984.
14. Hill, C.A., Harle, T.S. Mansell, P.W.: "The Prodrome, Kaposi Sarcoma and Infections Associated with Acquired Immunodeficiency Syndrome: Radiologic Findings in 39 Patients," *Radiology* 393-399, 1983.

15. Cohen, B.A., Pomeranz, S., Rabinowitz, J.G., *et al.*: "Pulmonary Complications of AIDS: Radiologic Features," *AJR* 143:115-122, 1984.
16. Barron, T.F., Birnbaum, N.S., Shane, L.B., *et al.*: "*Pneumocystis carinii* Pneumonia Studied by Gallium-67 Scanning," *Radiology* 154:791-793, 1985.
17. Overland, E.S., Nolan, A.J., Hopewell, P.C.: "Alteration of Pulmonary Function in Intravenous Drug Abusers: Prevalence, Severity and Characterization of Gas Exchange Abnormalities," *Am J Med* 68:231-237, 1980.
18. Glassroth, J.: "The Pulmonary Complications of AIDS. Evaluating the Tests," *Chest* 87:562-563, 1985.
19. "Leads from the MMWR Update: Acquired Immunodeficiency Syndrome—United States," *JAMA* 255:593-598, 1986.

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The Challenge of An Aging Population

By Marilyn J. Leyland (John), Peoria

People are living longer. Medical advances and generally improved living conditions have contributed to the longevity revolution. As Dr. Edward Schneider, deputy director of the National Institute on Aging, has said, people die from disease rather than from old age. As physicians aggressively treat the diseases, life expectancy increases.

In 1900, average life expectancy in the United States was 45 years; today it's 75. The population of those aged 85-plus forms the fastest growing group in the country. Postwar baby boomers, now reaching 40, are moving the median age rapidly upward.

The challenge to the baby boom generation is first of all to emphasize a healthy lifestyle for themselves, their parents and their children. The AMA Auxiliary's Shape Up for Life campaign, covering such elements as diet, exercise and stress management, promotes this approach.

The AMA Auxiliary strongly believes that, with help from the community, older Americans can lead rich and productive lives. The 1985-86 Shape Up for Life campaign focused on "Community Services for Older Americans." The Auxiliary resolved to ensure that state and county auxiliaries would establish and support programs for the elderly to help improve their quality of life.

Since the vast majority of older citizens are not sick, programs on behalf of the elderly should place emphasis on keeping them well. Education programs can help to prevent illness. The Illinois Auxiliary's Medi-Card helps to avoid problems with drug interactions. Social programs can assist in basic needs, fight loneliness, and provide special bright touches in the lives of seniors.

Increasingly, the women of the baby boom will be called upon to parent their parents. According to *American Demographics* magazine, "For the first time, American women can expect to spend more years caring for an aging parent than for a dependent child."

In 1940, only 37 percent of 50-year-old women had living mothers, but by 1980, the percentage had jumped to 65 percent.

Unquestionably, these changes will affect the doctor's wife. For one thing, the parents of doctors and their spouses can be presumed to receive good health care, leading to longer lives. Also, because doctors are seen as having monetary resources, the doctor's family often has the primary responsibility for aging members.

Medical auxiliary members already are developing expertise in caring for the needs, whether basic or extenuating, of aging family members. Many have experienced first-hand the decisions on nursing homes versus other alternatives and the effects of various chronic conditions.

Support groups for these Auxiliary members can provide a valuable service, allowing them to share their experiences and lighten their sense of burden. Ultimately, they can in turn serve as resources for the larger community, addressing the varied needs of the elderly.

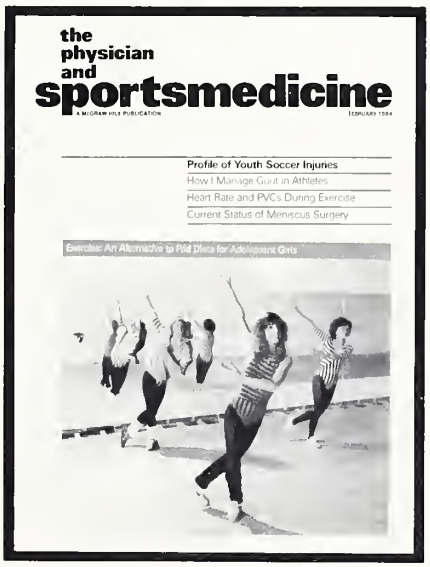
Doctors and their spouses have major roles to play personally, professionally and within the community as the American population ages. ◀



The Illinois Delegation to AMAA. Standing left to right: Norma Kiessel, Barbara Wanless, Becky Mauch, Barbara Newman, Evelyn Hodes, Evelyn Perlmutter, Vivian Reardon. Seated left to right: Betty Szewczyk, Sherry Betsill, Pat Spadoni, Lynn Kassel, Suzanne Meirink, Ruth Scrivner.

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October

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, October 31-November 2, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Ob/Gyn/Geriatrics/Pediatrics/Urology

Medical Seminar-at-Sea (Mediterannean/Holy Land Cruise)
For: Physicians. October 19-November 1. **Sponsor:** Southern Illinois University School of Medicine, CME, Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Family Medicine

17th Family Medicine Review
For: Family physicians. Course, October 26-31. **Sponsor:** University of Kentucky College of Medicine, Office of CME, 132 COM Office Building, Lexington, KY 40536. **Fee:** $425 ($450 after 10/10). **Reg. Limit:** None. **Credit:** Category 1: 50 hours; AAFP: 50 hours. **Contact:** Rosemary Fischer. **Phone:** (606) 233-5264.

Neurology

Clinical Neuroimmunology IV: Demyelinating Diseases and AIDS
For: Neurologists. Course, October 23-25. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Surgery

The Chicago Temporal Bone Surgical Dissection
For: Otolaryngologists. Course, October 6-10, Hinsdale Hospital, Hinsdale, IL. **Sponsor:** Dept. of Otolaryngology, Northwestern, Loyola University and Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521. **Fee:** $900-physicians; $600-residents. **Reg. Limit:** 8. **Credit:** Category 1: 40 hours. **Contact:** Cherie Jones, MPH. **Phone:** (312) 887-2400.

A Curative Approach to Sarcomas
For: Oncologists, pathologists, orthopaedic surgeons and radiation therapists. Course, October 17-18, Nordic Hills Resort, Itasca, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $75. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Elective: 7 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine/Internal Medicine

Comprehensive Care of the Diabetic Patient: An Update
For: Internists, family practitioners, and endocrinologists. Course, October 11, 9:00 a.m.-1:00 p.m., Highland, IN. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $30. **Reg. Limit:** None. **Credit:** Category 1: 3 hours; AAFP Elective: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Obstetrics/Gynecology

Perinatal Medicine-Back to the Basics
For: Perinatalogists, neonatalogists, and obstetricians. Symposium, October 16-17, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 13 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiology

Echocardiography 1986
For: Cardiologists and echocardiographers. Course and workshop, October 21-24, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $350. **Registration Limit:** 250. **Credit:** Category 1: 26 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolaryngologists. Laser Workshop, October 27-28, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Pentenney. **Phone:** (312) 908-8533.

Ear, Nose, and Throat Practicum
For: Physicians. Conference, October 9-10, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 17.25 hours; AAFP Prescribed: 17.0 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Surgery

Hemodynamic Monitoring
For: Physicians. Conference, October 2-3, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 10 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Pediatrics

Perinatology/Neonatology 1986: Compromised Fetus, Perinatal Problems, High-tech Neonatology
For: Neonatologists and pediatricians. Conference, October 16-17, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 13.25 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Occupational Medicine/Family Medicine

Impairment Evaluation & Disability Considerations: Medical & Legal Perspectives.
For: Physicians. Conference, October 27-29, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 15.5 hours; AAFP Prescribed: 15.5 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Allergy/Immunology

Update in Allergy and Clinical Immunology III-1986
For: Physicians and other health professionals. Conference, October 2-3, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Department of Medicine, School of Medicine, University of Wisconsin-Madison, and University of Wisconsin Hospital and Clinics. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA Category 2-D: 13 hours; and Univ. of Wisconsin CEUs: 13 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Neurology/Surgery/Radiology

Neuroradiology 1986
For: Physicians and other professionals. Conference, October 17-18, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Department of Radiology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours, University of Wisconsin CEUs: 10 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Urology/Surgery

Surgical Treatment of Urinary Incontinence
For: Physicians. Conference, October 23-24, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Departments of Surgery and Obstetrics and Gynecology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 15 hours, University of Wisconsin CEUs: 15 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pediatric Rheumatology

Update: Pediatric Rheumatology
For: Rheumatologists and pediatricians. Seminar, October 30, Chicago, IL. **Sponsor:** LaRabida Children's Hospital and Research Center, East 65th St. at Lake Michigan, Chicago, IL 60649. **Fee:** $60. **Reg. Limit:** None. **Reg. Deadline:** October 22. **Credit:** Category 1: 7 hours. **Contact:** Helen Emery, M.D. **Phone:** (312) 363-6700, x520.

Internal Medicine

Specialty Review in Hematology
For: Hematologists, internists and oncologists. Lecture, October 6-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 43 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Application of Clinical Pharmacology to Daily Practice

For: Physicians and other health professionals. Conference, October 10-11, Madison, WI. **Sponsors:** University of Wisconsin-Madison, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705, Department of Medicine, School of Medicine, and University of Wisconsin Hospital and Clinics. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; AAFP Prescribed: 11 hours; AOA Category 2-D and University of Wisconsin CEUs: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Medicine/Law

Medicine and the Law
For: Physicians and hospital administrators. Symposium, October 9, 1:00-5:30 p.m., Abraham Lincoln Memorial Hospital, Lincoln, IL. **Sponsors:** SIU School of Medicine, Illinois State Medical Society, and North Central RHEC. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Judith Gordon. **Phone:** (217) 732-2161, Ext. 452.

Family Medicine

Head & Neck Problems: Can Plastic Surgery Help?
For: Primary care physicians. Seminar, October 16, St. Louis, MO., Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100 **Reg. Limit:** 150. **Credit:** Category 1: 6.75; AAFP Prescribed: 6.75 hours; and ADA: 7 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Medicine and Family Practice

GI and Endocrine Update-A Multidisciplinary Approach
For: Physicians and other health professionals. Symposium,

October 31-November 1, Decatur, IL. **Sponsor:** Decatur Memorial Hospital, 2300 N. Edward St., Decatur, IL 62526. **Fee:** $25 for physicians, $15 for non-physicians, and no charge to residents. **Reg. Limit:** None. **Credit:** Category 1: 4.5 hours; AAFP Prescribed: credit applied for. **Contact:** Emily Crews. **Phone:** (217) 877-8121, Ext. 2115.

Psychiatry

Child and Adolescent Depression and Suicide

For: Physicians and other health professionals. Conference, October 31-November 1, Madison, WI. **Sponsor:** Center for Affective Disorders, Department of Psychiatry, University of Wisconsin, 600 Highland Avenue, Madison, WI 53792. **Fee:** $175 for physicians and $100 for others. **Reg. Limit:** 500. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; and University of Wisconsin CEU's: 1.2 hours. **Contact:** Dorothy Davidson, Ph.D. **Phone:** (608) 263-9751.

Pathology

Advances in Anatomic and Clinical Pathology

For: Pathologists. Lecture, October 20-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $630. **Reg. Limit:** 90. **Credit:** Category 1: 51 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Infectious Diseases

Advances in Control of Nosocomial Infection-1986

For: Physicians and other health professionals. Conference, October 23-25, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705; Infection Control Unit, Department of Medicine, School of Medicine, University of Wisconsin-Madison. **Fee:** To be announced. **Reg. limit:** None. **Credit:** Category 1: 16 hours; AAFP: credit pending; University of Wisconsin CEU's: 16 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pediatrics

Seminar in Pediatrics

For: Physicians and other health professionals. Conference, October 24-25, Madison, WI. Sponsor: University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed: 10 hours; AOA Category 2-D and University of Wisconsin CEU's: 10 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Surgery

Specialty Review in General Surgery, Part 1

For: General and specializing surgeons. Lecture, October 27-November 7, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880. **Reg. Limit:** None. **Credit:** Category 1: 96 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

NOVEMBER

Allergy

Clinical Allergy For the Practicing Physician

For: Physicians. Seminar, November 6-8, St. Louis. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $175. **Reg. Limit:** 150. **Credit:** Category 1: 19.25 hours; AAFP Prescribed: 19 hours; AOA: 19.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Anesthesia

Workshop in Fiberoptic Endoscopy

For: Anesthesiologists. Lecture, November 8, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $225. **Reg. Limit:** 50. **Credit:** Category 1: 7 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiac Rehabilitation

For: Physicians and other health professionals. November 10-14, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and the Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Geriatric Medicine

43rd Annual Scientific Meeting of American Geriatrics Society and 7th Annual Meeting of American Federation for Aging Research

For: Physicians. Convention, November 16-19, Chicago, IL. **Sponsors:** American Geriatric Society, 10 Columbus Circle, Rm. 1470, New York, NY 10019; American Federation for Aging Research. **Fee:** $125 (members), $150 (non-members). **Reg. Limit:** None. **Credit:** Category 1: 27 hours; AAFP Prescribed: 27 hours. **Contact:** Barbara Popecki. **Phone:** (212) 582-1333.

Neurosurgery

Neurosurgery Laser Workshop

For: Neurosurgeons. Workshop, November 17-18, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Registration Limit:** 12. **Credit:** Category 1: 19 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Obstetrics/Gynecology

Hysteroscopy Workshop

For: Gynecologists. Conference and workshop, November 14-15, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $325. **Reg. Limit:** 150. **Credit:** Category 1: 11.5 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Obstetrics/Gynecology/Family Medicine/Pediatrics

New Technologies in Clinical Genetics

For: Ob/Gyn's, pediatricians and family practitioners. Lecture, November 15, Holiday Inn-Alsip, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $35. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Elective: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine

Child Abuse

For: Physicians. Conference, November 3-5, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 18 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Surgery

Ins & Outs of Critical Care

For: Physicians. Conference, November 11-12, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 12 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Continuous Monitoring by Venous Oximetry

For: Physicians and allied health professionals. Conference, November 14. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6.25 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Michigan Society of Critical Care Medicine

For: Physicians. Conference, November 15, Ann Arbor, MI. **Sponsor:** Michigan Society of Critical Care Medicine, Townsley Center, Box 0201, Ann Arbor, MI 48109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Internal Medicine/Family Medicine

Management of Thromboembolism: Update 1986

For: Internists and cardiologists. Symposium, November 1, 8:00 a.m.-5:00 p.m., Chicago. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 8 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

AIDS: Understanding and Managing the Disease

For: Internists, family practitioners, and general practitioners. Symposium, November 7, 8:00 a.m.-5:00 p.m., Evanston Hospital, Evanston, IL. **Sponsors:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Avenue, Chicago, IL 60611; and Evanston Hospital, Department of Medicine. **Fee:** $50. **Reg. Limit:** None. **Credit:** Category 1: 8 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Focus on Rheumatology-1986

For: Physicians and other health professionals. Conference, November 7-8, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705; Department of Medicine, School of Medicine; and University of Wisconsin Hospital and Clinics. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed: 10 hours; AOA Category 2-D and University of Wisconsin CEU's: 10 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Perspective in Diabetes Mellitus 1986

For: Physicians and other health professionals. Conference, November 14-15, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Department of Medicine, School of Medicine. **Fee:** To be announced. **Reg. limit:** None. **Credit:** Category 1: 12 hours; AAFP Prescribed: credit applied for; AOA Category 2-D and University of Wisconsin CEU's: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Surgery

Medical and Surgical Approaches to pulmonary and Esophageal Diseases

For: Physicians and other health professionals. Conference, November 7-8, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Department of Surgery, School of Medicine. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; AAFP Elective: credit applied for; AOA Category 2-D and University of Wisconsin CEU's: 9 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Geriatrics

Aging and Illness in Primary Care: The 5th Symposium on Clinical Problems and the Future of Health Care of the Elderly

For: Physicians and other health professionals. Symposium, November 13-14, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Departments of Medicine and Family Medicine, School of Medicine; and Geriatrics Institute, Mt. Sinai Medical Center. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 15 hours; AAFP Prescribed: credit pending; AOA Category 2-D: pending; and University of Wisconsin CEU's: 15 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pediatrics

National Studies of Perinatal Care

For: Pediatricians and family physicians. Seminar, November 15, St. Louis, MO. Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours. Loretta Giacoletto. **Phone:** (800) 325-9862.

DECEMBER

Obstetrics/Gynecology

Advanced Colposcopy and Laser Surgery

For: Gynecologists. Conference and workshop, December 4-6, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $325. **Reg. Limit:** 110. **Credit:** Category 1: 16 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Problem Solving in Gynecologic Endocrinology and Infertility

For: Obstetricians and gynecologists. Course, December 12-13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Otolaryngology

Otolaryngology Head and Neck Workshop

For: Otolaryngologists. Laser workshop, December 8-9, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Neurology

Neurology for the Non-Neurologist

For: Family practitioners, internists, and psychiatrists. Lectures/workshops, December 10-12, Chicago. **Sponsor:** Rush University, Rush Presbyterian-St. Luke's Med. Center, University Office of CME, 600 S. Paulina, Chicago, IL 60612. **Fee:** To be determined. **Reg. Limit:** none. **Credit:** Category 1: 20 hours; AAFP elective: Credit applied for. **Contact:** Barbara Trejo. **Phone:** (312) 942-7095.

Surgery

Symposium on Vascular Emergencies

For: Surgeons. Symposium, December 11-13, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $450. **Reg. Limit:** 500. **Credit:** Category 1: 16.5 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Family Medicine

Low Back & Sciatic Pain: Evaluation & Treatment

For: Physicians. Seminar, December 12-13, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. Limit:** 150. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; and AOA: 12 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CARBONDALE:
Multi-specialty group needs the following physicians: Otolaryngologist, Ophthalmologist, Neurologist and OB/GYN physician. Contact Wayne Given, 2601 West Main, Carbondale 62901. (6)

FAIRFIELD:
Family oriented Southern Illinois community with 50 bed, full service hospital recently undergoing extensive renovation seeks board certified and residency trained family practitioner to join an established young practitioner as an associate in a busy practice. Must be qualified in, and enjoy obstetrics, as this is a major portion of the practice. A fully equipped clinic with x-ray and lab facilities is available. The service area of this community is 25,000 and there are presently only 5 full time physicians in the area. Guaranteed salary with incentive. This is an excellent opportunity for a physician who wishes to establish a practice quickly and to be financially comfortable in a small community which is an excellent place for raising children. Send CV to Michael A. Blood, M.D., Fairfield Memorial Hospital, Fairfield 62837, or call 618-673-2135. (6)

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

OAK PARK
Several excellent opportunities immediately available to replace retiring family practice physicians in western suburbs of Chicago. Hospital will provide generous income guarantee, and practice-building and management expertise. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Full time faculty position. Assistant Director of Family Practice center. Responsibilities include teaching in an outpatient setting, monitoring residents, and teaching procedural skills. Some direct patient care. Excellent compensation and benefits. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Two immediate care centers in near west suburbs of Chicago have full and part-time positions immediately available. Opportunity to develop private practice if desired. Hospital will support practice. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Freestanding occupational health centers associated with prestigious community hospital in western suburbs of Chicago have immediate openings for both full and part-time physicians. Excellent compensation. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Growing, 374-bed community hospital in near-west suburb of Chicago seeks board eligible or board certified pediatricians to associate with existing practices. Salary to start, working into partnership. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

CLASSIFIED ADVERTISING

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6 insertions	18.00	44.00	64.00	108.00
12 insertions	22.00	53.00	79.00	132.00

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POSITIONS AND PRACTICE

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Allison Katz, Staffing Specialist. National Emergency Services, Inc., 255 Executive Drive, Suite 104, Plainview, NY 11803 or call (800) 645-4848 or (516) 349-0100.

ARIZONA BASED Physician recruitment firm has opportunities coast to coast. "Professionals working with Professionals." Over 14 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PRACTICE/Internal Medicine—Central Illinois. Various opportunities available: solo and group. Reply to Box 1186, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WELL ESTABLISHED PRACTICE for sale. General practice and general surgery. Chicago suburb. Will introduce up to one year. Grossing over $200,000. Reply to Box #2006, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SURGEON: Looking for associate in the established practice of general surgery. Suburb of Chicago. Reply to Box #2007, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

IMMEDIATELY NEEDED: Family practice/internist. Guaranteed $35/ hour plus percentage. Close to St. Louis. Hospital privileges: community and St. Louis. Call (618) 254-7478.

PHYSICIANS NEEDED for opportunities in Arizona. Send C.V. to: Fred Wellhausen, Western Personnel, 316 E. Flower, Phoenix, AZ 85012.

INDUSTRIAL CLINIC needs physician part-time weekdays in southwest suburb. Need Illinois license and your own malpractice. Send resume and hours available to: Southwest Industrial Care, 7600 W 119th St, Palos Heights, IL 60463.

FAMILY PRACTICE—Immediate need for two B/C family practitioners for opportunity in Phoenix, AZ. For more details, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

IMMEDIATE OPENING full-time emergency physician at trauma center southwest of Chicago. Considerable exposure to acute trauma. Partnership within one year, remuneration exceeding six figures. Must be board certified in internal medicine, or at least two/three years experience in emergency medicine. Contact W. L. Gordon, (815) 744-2800.

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE OB/GYN, FP, pediatric physicians coast to coast. For further information, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PHYSICIAN AND PEDIATRICIAN—Michigan City, Indiana, 50 miles southeast of Chicago. Thirty-physician multispecialty group. Two fully accredited acute care hospitals with over 300 total beds. Modern, fully equipped clinic. Michigan City has a population of 60,000 with over 100,000 drawing area. Competitive salary, full benefits. Located on Lake Michigan. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice, pediatrics and OB-GYN. Positions include income guarantee and no capital investment. For more information, contact Barry Trautman, 8401 Hanley Industrial Ct., St. Louis, MO 63144, (314) 962-1233.

INTERNAL MEDICINE—Shelbyville, Indiana, 25 miles southeast of Indianapolis. Eight-physician multispecialty group seeking third internist. Modern fully equipped clinic, in-house lab. Ninety-bed hospital, 6-bed ICU. Competitive salary, full benefits. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

EXPERIENCED REPRODUCTIVE Endocrinologist is wanted for an IVF program. Board certification/eligibility, in OB/GYN, experience in infertility, fellowship in reproductive endocrinology, experience in reproductive sonography and surgery are mandatory. Laboratory skills in reproductive endocrinology/immunology are needed. Send C.V. to Norbert Gleicher, M.D., Chairman, Department of Obstetrics and Gynecology, Mount Sinai Hospital Medical Center, California Ave. at 15th St. Chicago, Illinois 60608.

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ter, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman at Healthline Physician Services, 8401 Hanley Industrial Ct., St. Louis, MO 63144.

PEDIATRICIAN/OTOLARYNGOLOGIST— Canton, Illinois, Nine-physician multispecialty group, 225-bed hospital/trauma center, 22 pediatric beds. Clinic includes lab, x-ray, out-patient surgery. Hospital staff of 45/ strong referral base. Excellent salary. Complete benefits. Contact: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call (414) 785-6500 collect.

ORTHOPAEDIC SURGEON: Berwyn, Illinois. Needed—board certified/eligible orthopaedic surgeon to join active practice. Competitive first year guarantee leading to partnership available. Berwyn is a western suburb of Chicago. Reply to Box #2014, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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FAMILY PRACTITIONER Board certified or eligible to associate with general surgeon with well established Waukegan practice. Must be fluent in Spanish and English. $50,000 yearly guaranteed with fringe benefits and malpractice. Illinois license required. Reply to Box #2018, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PEDIATRICIAN TO JOIN well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL 60178.

FAMILY PRACTICE SPECIALIST. Marshfield Clinic department of family medicine is seeking a BE/BC family practitioner to replace a retiring colleague. The physician joining this six member department will enjoy the support of one of the nation's largest multispecialty groups, share the philosophy of family oriented care with a preventive focus, and enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Marshfield Clinic offers an excellent salary plus extensive fringe benefits. Please send curriculum vitae to: John Folz, Assistant Director, Marshfield Clinic, Marshfield, WI 54449, or call collect at (715) 387-5181.

UNIVERSITY HEALTH SERVICE: Twelve month position in primary care to young adults with major responsibility for sports medicine program. Illinois license or eligibility therefore. Completion of residency and board certified preferred. Significant sports medicine/trauma experience required. Student population 26,000, accredited health service. Semi-rural community of 30,000 with many cultural advantages, 1½ hours from Chicago. Inquiries with C.V. to: Rosemary B. Lane, M.D., Director, NIU Health Service, DeKalb, IL 60115-2879. (815) 753-1314 for further information. EOE/AA employer.

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WANTED—E.R. Physicians—STAT,P.C., a professional corporation providing St. Joseph Mercy Hospital emergency department physician services, looking for qualified part-time or full-time physicians to staff the emergency department. Please direct inquiries to Lambert C. Orton, M.D., STAT,P.C., 84 Beaumont Drive, Mason City, IA 50401. (515) 424-STAT(7828).

EFFINGHAM, ILLINOIS: Population 18,000. St. Anthony's Memorial Hospital is seeking an anesthesiologist to develop and direct our anesthesiology department, consisting of one other anesthesiologist and four CRNAs. Current surgical volume consists of 2,000 inpatient visits and 1,400 outpatient visits. Effingham is located approximately 200 miles south of Chicago, at the crossroads of Interstates 57 and 70. Contact: Robert Esker, St. Anthony's Memorial Hospital, 503 N. Maple St., Effingham, IL 62401. Phone: (217) 347-1324.

GREEN BAY, WISCONSIN: 27 physician multi-specialty group seeking BC/BE physicians in the following specialties: family practice, ophthalmology, dermatology, plastic surgery, radiology, OB-GYN, internal medicine and pediatrics. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The clinic offers competitive salary and excellent fringe benefits. Interested physicians please contact: W. J. Mommaerts, Administrator, West Side Clinic, S.C., 1551 Dousman Street, Green Bay, WI 54303.

OB/GYN's—We represent clients in Illinois, Iowa, Michigan, Montana, North Dakota, and Wisconsin. Opportunities with multispecialty groups, partnerships, and solo fee-for-service positions are available. For detailed information, please send your C.V. or call: Jim Huber, Fox Hill Associates, 250 Regency Ct., Waukesha, WI 53186, (414) 785-6500 (collect).

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PHYSICIANS: Part time/on call, day and night positions available in ambulatory services and internal medicine departments for physician, family practice/internal medicine. Must have completed residency training and possess current Illinois license. Direct all inquiries with curriculum vitae to: Medical Administration, Oak Forest Hospital, 15900 S. Cicero Ave., Oak Forest, IL 60452. Equal opportunity employer.

POSITION AVAILABLE for associate director of internal medicine in ambulatory care at MacNeal Hospital, an affiliate of Rush-Presbyterian-St. Luke's Medical Center. Applicants should have teaching and administrative experience and be certified or board-eligible in internal medicine. Sub-specialties will be considered. Responsibilities will include clinical and teaching activities of students and residents with a major commitment to an ambulatory care curriculum. Opportunities for research and private practice are available. Address inquiries and curriculum vitae to: Lawrence R. LaPalio, M.D., Medical Education, MacNeal Hospital, 3249 S. Oak Park Ave., Berwyn, IL 60402; (312) 795-3400.

SEEKING PSYCHIATRIST for community mental health center. One day per week (3-5 hours) a.m. or p.m. Responsibilities include: psychiatric evaluations, medication maintenance and follow-up. Available immediately. Good position for recent graduates or someone just completing their residency. Contact: Richard De Frank, Portage Cragin Counseling Center, 4840 West Byron Street, Chicago, Illinois 60641; (312) 282-7800.

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INTERNIST SEEKS part or full time position: days, evenings, or nights Chicago metropolitan area. Experienced in occupational/ industrial and general practice. University trained. Reply to Box #1198, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors,

medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

WANTED: PRIVATE PRACTICE. General or internal medicine. Chicago or near suburbs. Reply to Box #2019, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED general surgeon seeks suitable position. Willing to do some general practice. Will also consider HMO, minor surgery centers and emergency care centers. Reply to Box #2024, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

WANTED TO BUY: General practice or general practice with surgery. Prefer small or medium size community. Could take over the practice immediately. Has current Illinois license. Reply to Box #2025, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED PEDIATRICIAN seeks part-time position in Chicago and suburbs. Reply to Box #2022, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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PRACTICE FOR SALE. Well-settled moderately busy, eight-year old pediatric practice located in northwest side of Chicago. Low rent and overhead. Terms negotiable. Call (312) 973-7362 evenings.

MEDICAL SUITES: Modern 2/3 examining room suites available. Includes private office with washroom, reception area. Northwest Chicago location. Contact Baird & Warner (312) 855-5306.

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ELGIN AREA-PEDIATRIC Practice: Owner netting 50% of $400,000 gross. Beautiful offices. Asking $200,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

MEDICAL BUILDING for sale (6,300 square feet) or lease (925 square feet). Formerly chiropractor's office. 1497 Vandalia, Collinsville, IL. Presently divided into seven rooms. Ideal location for a medical office. Close to Oliver Anderson Hospital. Utilities included. Plenty of parking. $700. Call (314) 842-4038.

SOUTHEAST CHICAGO profitable industrial & general medical clinic available. Busy practice grossing approx. $1,800,000. Write Box #2020, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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BUSY FAMILY PRACTICE. Southwestern suburbs. Twenty miles from Chicago Loop. $300K gross yearly. Reply to Box #2026, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE—Medical building. One story masonry with 8 suites, pharmacy, extra large waiting room and receptionist area. Paved parking lot. Excellent location for public transportation. Expense list and leases available. Owner request lease back. For additional information and personal viewing call: O'Flaherty & Bolhouse Realtors, Inc., (312) 430-1000.

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SOUTHWEST SUBURBAN (Near Oak Lawn) medical center. Grossing $1,300,000. Owner wishes to stay on, handling his speciality. Well equipped. Write Box #2021, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SW CHICAGO (Summit area): General practice. Owner grossing $100,000+. Asking $175,000 for practice and real estate. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

SELLING FAMILY PRACTICE Southside. Grossing $125,000. Working 3 hours. More potential if fulltime devoted. Selling cheap with equipment. Relocating. Excellent office. (312) 333-6789 evenings/weekends.

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Three Ways to Make a Difference



This month, the annual reference issue of the *IMJ* provides listings of all the state and county society officers, and ISMS council and committee members and chairmen. The responsibilities and purposes of the councils and committees are explained, and the constitution, bylaws and official policies of the Society are published.

The council and committee structure is designed for communication. Any member can easily contact a council or committee member to give direct input into these groups. Most questions or ideas should not be sent directly to the Board of Trustees. It's more efficient to be in contact with the appropriate council or committee, where the expertise and resources are available for an in-depth discussion. Recommendations, with supporting materials, are then sent to the Board of Trustees for discussion and action.

If you feel that your commitment to organized medicine could be extended, look over the listed councils and committees in this issue. Look for places where you might become more involved, and when you've found them, get in touch with your district trustee. Each spring, the chairman of the Board of Trustees reconstructs the councils and committees for the next year. He looks to the officers and trustees for suggestions.

If you are not selected the first time, make yourself available—be patient and keep trying. Some councils are heavily sought after, so there might be a little delay. However, a member who wants to become more active will not have the opportunity unless he or she makes this fact known. If a person desires to move up in leadership, they must make their value and expertise known at this level, so that more and more responsibility may be offered. Nothing worthwhile at any level just happens—there must first be an effort exhibited toward an objective.

By this time, I would hope that every physician and eligible medical family member has registered to vote. We have an opportunity this November to elect a state senate that would be responsive to us and a state legislature more responsive than before. If you have the opportunity to participate in the campaigns of those who have been our friends, please do so. It is very important. And by all means, vote on November 4.

The annual All-Member Conference will be held on November 8-9 at the Drake-Oakbrook. Here we will learn grassroots methods to convince newly-elected state government members of the desperate need for further tort reform. As was said before, at least one member from every hospital medical staff in Illinois should be present. ◂

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President

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ISMS All-Member Conference
November 8, 1986

Restoring the Balance

The ISMS All-Member Conference will be held Saturday, November 8, at the Drake-Oakbrook Hotel. It promises to be a stimulating, fast-paced day of seminars and debate. Physicians and spouses who attend will leave with a firm grasp of legislative strategy for 1987, as ISMS maps the path to crucial malpractice reforms.

Registrants for the ISMS All-Member Conference should plan to arrive at the Drake-Oakbrook hotel by 6:00 on Friday evening, November 7, for a "get acquainted" cocktail reception.

The ISMIE Network will meet for breakfast on Saturday, November 8 at 8:00. All conference participants are invited. The new ISMIE claims-made product will be the main topic for discussion, but the breakfast provides a forum for all questions and concerns.

The formal program begins at 9:00 a.m., when Cook County Circuit Court Judge Edwin Berman will give the opening address with his perspective on the impact of the Illinois Supreme Court rulings on the 1985 malpractice reform legislation.

Morning presentations will include key legislators' predictions on how the November elections will influence the outcome of proposals of interest to medicine. Special focus will be given to legislative arguments for and against caps on non-economic damages. Speakers will also include experts in physician contracting issues.

The luncheon speaker, F. Lee Bailey, will talk about the image of the judicial system in America today. Mr. Bailey is a colorful, articulate defense attorney with extensive litigation experience.

Afternoon sessions will cover expected developments as the General Assembly considers the Medical Practice Act under "sunset" review this session. A special seminar on media relations will highlight skills & strategies in working with members of the media in community education on public policy issues. Registrants will also have an opportunity to meet with other physicians from their legislative districts to discuss grassroots strategy for malpractice reform over the coming months.

The conference will close with a salute to Attorney General Neil Hartigan, who successfully defended the constitutionality of the 1985 medical malpractice legislation.

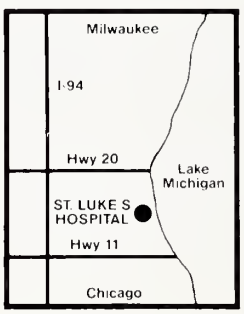
Conference registration of $50 for ISMS and ISMSA members will cover all materials and refreshments. Members seeking further information are urged to contact the ISMS offices: 312-782-1654; 1-800-782-ISMS. ◀



Dr. Joseph Geenen, Director of St. Luke's Digestive Disease Cente

Why are patients from Caracas, Venezuela, London, England & Hartford, Connecticut coming to Racine, Wisconsin?

People from all parts of the United States and abroad who suffer from unexplained abdominal pain and other internal disorders have found answers in Racine, Wisconsin. That's because the internationally acclaimed Digestive Disease Center at St. Luke's Hospital is located in Racine. This center, one of the few of its caliber, is staffed with physicians who serve as the leading authorities on gastric and digestive tract disorders in the United States—skilled specialists who have pioneered the most-up-to-date surgical techniques available anywhere. Expertise that is backed by sophisticated technology and state-of-the-art equipment.



The Digestive Disease Center at St. Luke's Hospital is unmatched in its commitment to complete diagnosis and individualized patient care, and has served as a forerunner in the treatment of polyps, ulcers, pancreatitis, gallstones and liver disease since its beginnings in 1973. If you have a patient you're interested in referring, give us a call at 636-2348 and we'll help you with patient arrangements. Or if you'd like more information, we'll send you a brochure about the center and answer any questions you may have.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Follow-up studies six months after coronary angioplasty revealed little change in patient behavior with regard to diet, exercise and smoking habits. Symptoms of angina pectoris requiring physician evaluation were common in these patients. (Fletcher, G.F.: *Arch Phys Med Rehab* 67:8,517-9, 1986)

Asymptomatic carotid bruit was followed in 500 patients during a four year span. A severe subclavian stenosis was noted in 45 patients, 64% of whom had a positive subclavian steal test. None of these patients developed symptoms secondary to arm exercises, and none developed strokes. Angiographic studies revealed most stenotic lesions occurring on the left side, possibly as a consequence of the acute angle at the origin of the left subclavian artery. The only rare symptoms noted were transient ischemic attacks of the vertebral-basilar arteries. Surgical treatment for stenotic lesions should be reserved for patients with disabling vertebrobasilar transient ischemic attacks. (Bornstein, N.M., Norris, J.W.: *The Lancet* 2:8502,303-5, 1986)

Zinc is required for normal immune function and taste acuity. It also enhances the *in vitro* effectiveness of insulin. Low serum zinc levels were noted in 16 of 180 patients with type II diabetes, although the serum levels did not relate to the diabetes control or explain the decreased taste acuity. Zinc deficiency may play a role, however, in the abnormal immune function in type II diabetes. (Niewoehner, C.B., *et al.*: *Am J Med* 81:1,63-9, 1986)

When myocardial infarction is suspected, creatine kinase and MB fraction should be done on admission and at 12 and 24 hours subsequently. Lactate dehydrogenase isoenzymes should be measured if a myocardial infarction continues to 24 hours or more in duration. Because of the poor sensitivity of single measurements, emergency room personnel should not use these assays to exclude myocardial infarction. (Lee, T.H., Goldman, L.: *Ann Int Med* 105:2,221-33, 1986)

Tourette syndrome, with multiple motor tics and involuntary vocalizations, was studied in 200 children and adolescents at the Cleveland Clinic. The mean age at onset was 6.3 years; the delay between onset and diagnosis was approximately 4.5 years. In 37% of the cases another family member in addition to the patient exhibited this syndrome. A large number (58%) had behavioral or learning disabilities or both. These disorders created more problems than the tics and noises. (Erenberg, G., *et al.*: *Cleve Clin Q* 53:2,127-31, 1986)

Events at birth and during the neonatal period accounted for a proportion of cerebral palsy only slightly higher than factors occurring before labor began. Maternal mental retardation, birthweight below 2001g and fetal malformation were among the leading predictors.

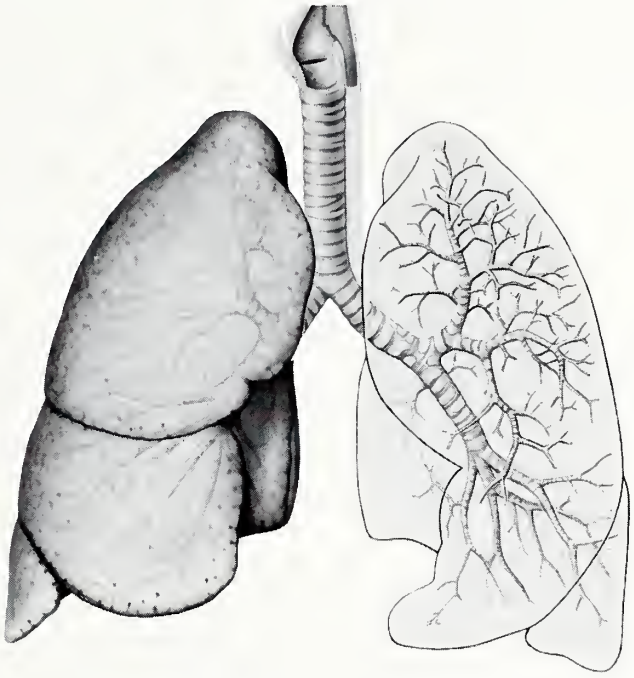
Breech presentation was also a predictor, with one third of the cases exhibiting a major non-cerebral malformation. Breech delivery was not, in itself, a factor in cerebral palsy.

Among 189 children with cerebral palsy, 21% had three clinical markers of asphyxia, and only 9% lacked major congenital malformation or other defects. (Nelson, K.B., Ellenberg, J.H.: *N Engl J Med* 315:2,81-7, 1986)

Needle electromyography detected abnormalities in 72% of women evaluated because of urinary retention, possibly mislabeled as psychogenic urinary retention. Changes indicating reinnervation were noted in 16 of 48 women tested, myotonic-like electrical activity was noted in 19 patients, and 13 patients showed normal urethral sphincters. (Fowler, C.J., Kirby, R.S.: *Lancet* 1:8496,1455-7, 1986)

Asymptomatic microhematuria occurred in 13% of normal adult males and postmenopausal women who had been referred to urology for additional work-ups. The frequency of serious urologic disease in patients with asymptomatic microhematuria was 2.3%, and of these, only 0.5% had bladder or renal carcinoma, particularly in the more elderly group. Complete urologic investigations in all patients with asymptomatic microhematuria may not be recommended. (Mohr, D.N., *et al.*: *JAMA* 256:2,224-9, 1986)

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- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

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- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

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- Transient fluctuations in leukocyte count (especially in infants and children)
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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Pedro A. Poma, M.D., Melrose Park, was installed as president of the Chicago Medical Society during the Society's annual meeting in June. Other elected officers are **Robert M. Vanecko, M.D.,** Chicago, president-elect, **James H. Andersen, M.D.,** Oak Brook, secretary, **M. LeRoy Sprang, M.D.,** Skokie, treasurer, **Ulrich F. Danckers, M.D.,** River Forest, council chairman and **H. Constance Bonbrest, M.D.,** Chicago, council vice-chairman.

The Institute of Medicine of Chicago has elected **Robert E. Lee, M.D., Ph.D.,** Park Ridge, president. Dr. Lee is affiliated with Lutheran General Hospital and the University of Illinois College of Medicine at Chicago.

Newly-elected medical staff officers for Jackson Park Hospital, Chicago, are **Harshad Mehta, M.D.,** Northfield, president, **Audley F. Connor, Jr., M.D.,** Chicago, vice president, **Syed Rahman, M.D.,** Chicago, secretary and **Terrold B. Butler, M.D.,** Chicago, treasurer . . . **Rabi F. Sulayman, M.D.,** Chicago, was appointed chairman of the department of pediatrics at Christ Hospital and Medical Center, Chicago . . . **Lawrence La Palio, M.D.,** Hinsdale, is the new academic director of internal medicine at MacNeal Hospital in Berwyn.

Henry B. Betts, M.D., Chicago, has been named chief executive officer and medical director of the Rehabilitation Institute of Chicago. Dr. Betts, who is also chief executive officer of the Institute's parent, the Rehabilitation Institute Corporations, is past president of the American Congress of Rehabilitation Medicine and founding president of the Association of Academic Physiatrists . . . Joan Rivers, in her new book, credits a local physician, **Herb Sohn, M.D.,** Chicago, with helping to launch her career. Dr. Sohn is a candidate for Congress from the ninth congressional district . . . The department of anesthesiology at the University of Illinois Hospital, Chicago, awarded its 1986 distinguished faculty and alumni award to **Max Sadove, M.D.,** River Forest. Dr. Sadove was affiliated with the university for 23 years and served as chairman of the department of anesthesiology from 1949 to 1971 . . . **Irwin Silverman, M.D.,** Deerfield, was named the 1985-1986 Attending Physician of the Year of Evanston Hospital. Dr. Silverman, who has now received the award for three consecutive years, was elected by the hospital's house staff.

Loyola University Medical Center, Maywood, has appointed **Sidney J. Blair, M.D.,** Oak Park, to the Dr. William M. Scholl Chair of Orthopaedics, **R. Morrison Hurley, M.D.,** Maywood, to the Maude C. Clarke Chair in Pediatrics, and **John H. Isaacs M.D.,** Evanston, to the Mary Isabelle Caestecker Chair in Obstetrics and Gynecology . . . A national service organization made up of U.S. citizens of Italian descent, UNICO, has named **August Martinucci, M.D.,** Joliet, 1986 Man of the Year. Dr. Martinucci, an ear, nose and throat specialist affiliated with Saint Joseph Hospital Medical Center, Joliet, is past chairman of the Will-Grundy County Medical Society legislative committee . . . **Anthony L. Barbato, M.D.,** Oak Park, will become the dean of the Loyola University Stritch School of Medicine on January 1, 1987. Dr. Barbato, an internist specializing in endocrinology and metabolism, will succeed **Dr. John R. Tobin, Jr.,** who retires December 31 after four years' service in that post . . . **Sadiq Mohyuddin, M.D.,** Godfrey, has begun his second term as president of the medical staff of Saint Anthony's Hospital, Alton. Dr. Moyhuddin, a past president of the Madison County Medical Society and a delegate to ISMS, is also chairman of the hospital medical staff executive committee.

MEDICAL HISTORY REQUEST

Martin S. Pernick, an associate professor in the department of history, University of Michigan, Ann Arbor, MI 48109, has written the *Journal* seeking information on medical or health-related motion pictures produced for lay audiences prior to 1928. The author of a work-in-progress titled BRINGING MEDICINE TO THE MASSES, he seeks copies of any such films or "leads" to pertinent reference material.

UI DEMOGRAPHICS

The June graduating class of the University of Illinois College of Medicine included 51 minority students, the highest number in the school's history. The group, composed of blacks, Hispanics and native Americans, represents 18% of the 287 graduates. Studies indicate that physicians tend to remain in the areas where they received their medical training to establish practices. Half of this group is entering residency programs in Chicago area hospitals.

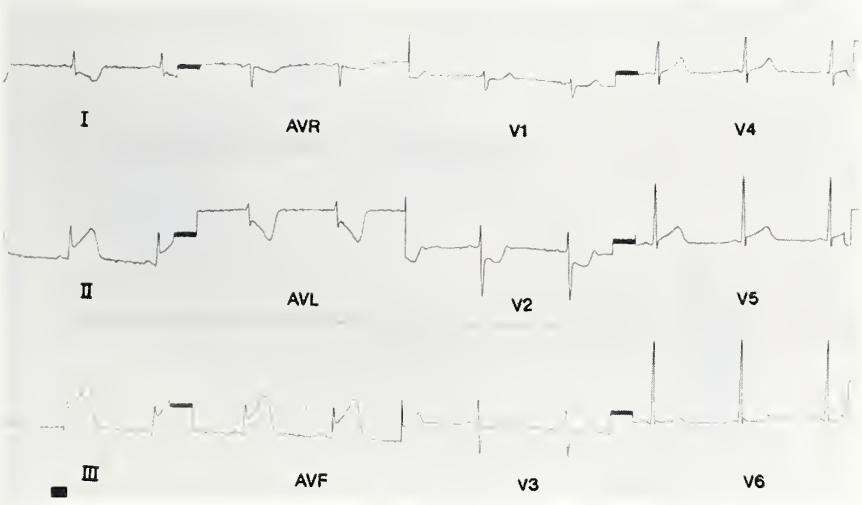
The college, which ranks high among public medical schools in the number of graduating minorities, established the Urban Health Program in 1979 to recruit, retain and graduate minority students. Its goal is to train minority health professionals who would dedicate themselves to improving quality health care availability in underserved areas in the state.

AMA ELECTIONS

Three Illinois physicians were elected to positions at the American Medical Association's House of Delegates meeting in June. **John J. Ring, M.D.,** a family practitioner from Mundelein and former ISMS trustee, was re-elected to the Board of Trustees and elected vice-chairman of the AMA Board. **Michael Nieder, M.D.,** a pediatric hematology fellow at Children's Memorial Hospital, was elected delegate to the Resident Physician Section Governing Council. **Ira R. Friedlander, M.D.,** Chicago, was re-elected to his third consecutive term as resident member of the AMA Council on Scientific Affairs. He is affiliated with the University of Chicago Hospitals and Clinics.

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a 36 year old male accountant and avid tennis player. He considered himself to be in good health, although he smoked two packs of cigarettes per day. About 45 minutes after a particularly difficult tennis match, he experienced a warm feeling that he described as "not quite right." This feeling disappeared after a short walk, but he soon became lightheaded, weak, and short of breath. He came to the emergency service. This ECG was obtained. His physical examination showed a blood pressure of 106/74mmHg and a pulse of 60 beats per minute. His lungs were normal and the cardiac exam only showed an atrial gallop. The examination was otherwise normal.

Questions:

1. **The twelve lead ECG shows:**
   A. An idioventricular rhythm with atrioventricular dissociation.
   B. A current of injury or ST segment elevation.
   C. Evidence of acute pericarditis.
   D. Evidence of acute inferior wall myocardial infarction.
   E. A junctional escape rhythm.

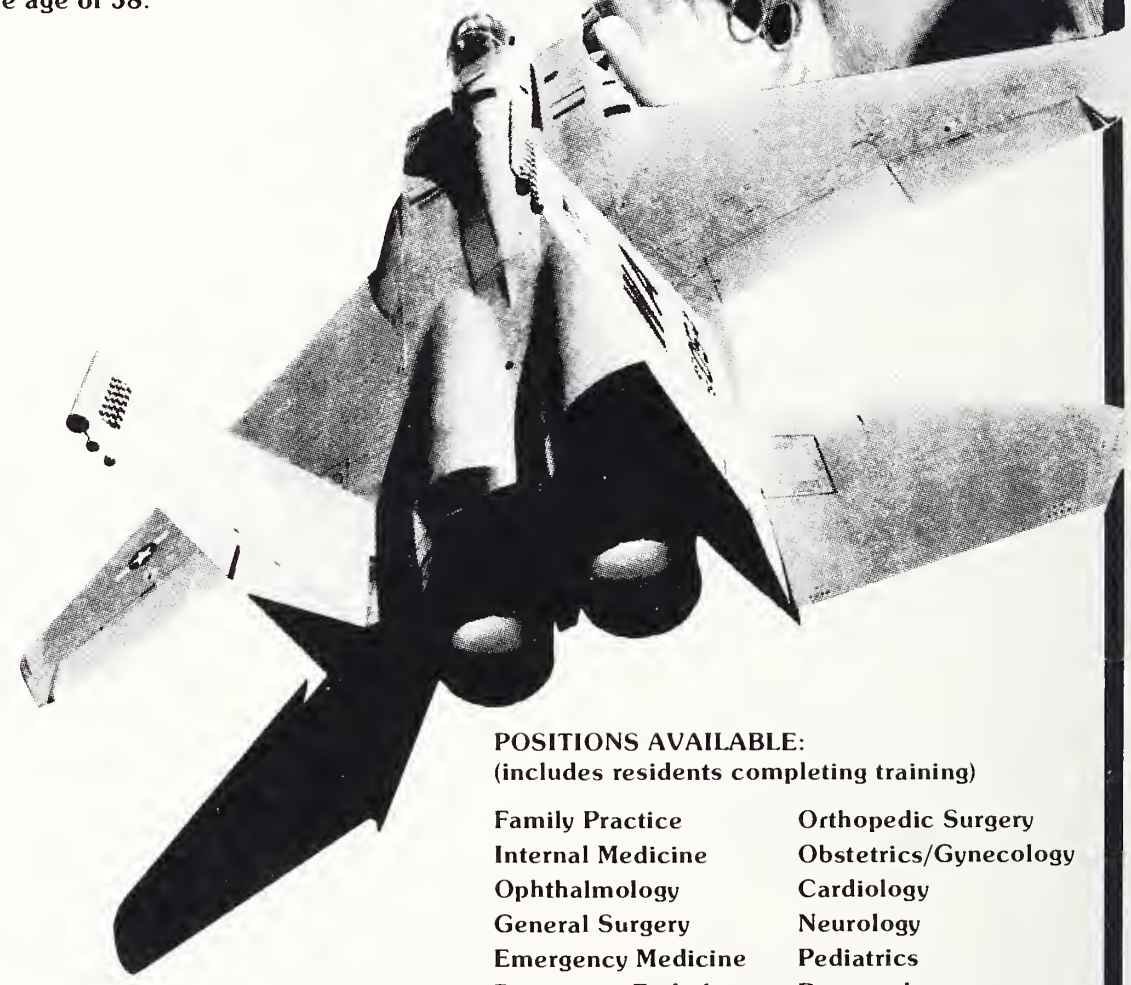
2. **Appropriate treatment measures could include:**
   A. Skin testing for tuberculosis.
   B. Corticosteroids with a plan for gradually lowering the dosage.
   C. Admission to the coronary care unit.
   D. Serial cardiac enzymes and electrocardiograms.
   E. Continuous electrocardiographic monitoring.

(continued on page 198)

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Society Addresses Public Health Issue

Smoking in Public Places

Last spring, the Illinois legislature considered House Bill 2600, sponsored by Rep. Robert Terzich (D-Chicago), which would have limited smoking in public places. Ultimately, the bill failed to pass, but its consideration permitted an airing of the issues and an opportunity for health education.

ISMS President Jere Freidheim testified before the House Executive Committee in support of H.B. 2600. He addressed the issue as a medical leader, a pediatrician and a former smoker.

Dr. Freidheim urged the committee to amend the Illinois Indoor Clean Air Act in order to limit smoking in public places. He pointed out that 36 states presently have legislation for that purpose. Speaking as a former smoker, he pointed out that smoking not only damages the lungs of those exposed to second-hand smoke but also presents unnecessary temptation to those who have "kicked the habit."

Dr. Freidheim's most persuasive comments may have been those related to his pediatric practice. He illustrated the spiral of human and economic costs for the committee.

"A number of studies have shown that women who smoke and women who are exposed to tobacco while they're pregnant tend to have smaller babies," he said. "When they're smaller like this, they have more medical problems. This is more costly. We have babies who aren't given the chance to fulfill their potential."

Dr. Freidheim also explained the relationship between childhood asthma and exposure to cigarette smoke in the home.

"Once the baby is born, one of the things I always tell the parents is, 'Please don't smoke around the child, the infant or other children. Don't let anybody else do it. When they're at home, you don't want them in rooms where people are smoking or rooms where there has been smoking.'"

The ISMS president also stressed the fact that the Society's position would go beyond simply limiting smoking in public places.

"The Illinois State Medical Society is committed to reducing cigarette smoking, period," he said. "We know this legislation is not aimed at that, but it does give some assistance to those who wish to be protected, who don't wish to subject their bodies to this noxious stimulant. Therefore, we would wholeheartedly support this bill."

The Society frequently provides expert testimony on health legislation. Physicians who are interested in assisting these efforts when specific bills are under consideration should advise the ISMS Governmental Affairs Division. ◀

OBITUARIES

****Berger, Samuel,** Chicago, died July 12, 1986 at the age of 82. Dr. Berger was a 1930 graduate of Rush Medical College, Chicago.

***Bernstein, Harold,** Carthage, died July 22, 1986 at the age of 73. Dr. Bernstein was a 1944 graduate of the University of Health Sciences/Chicago Medical School

***Bicoff, Juan P.,** Highland Park, died August 13, 1986 at the age of 61. Dr. Bicoff was a 1951 graduate of the Facultad de Ciencias Medicas de la Universidad Nacional de Cordoba, Cordoba, Argentina.

***Coleman, Jerry H., Jr.,** Chicago, died July 12, 1986 at the age of 76. Dr. Coleman was a 1949 graduate of the Meharry Medical College School of Medicine, Nashville, Tennessee.

****Fredberg, Clifford W.,** Rockford, died August 21, 1986 at the age of 86. Dr. Fredberg was a 1933 graduate of Rush Medical College, Chicago.

****Levee, Benjamin,** Chicago, died August 26, 1986 at the age of 86. Dr. Levee was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

***Peters, Howard R.,** Rockford, died August 24, 1986 at the age of 62. Dr. Peters was a 1946 graduate of the University of Illinois College of Medicine, Chicago.

****Rian, Oliver,** Cape Coral, Florida, died August 4, 1986 at the age of 81. Dr. Rian was a 1935 graduate of the Medical College of Wisconsin, Milwaukee.

***Sholder, Seymour,** Chicago, died August 27, 1986 at the age of 66. Dr. Sholder was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

****Soucy, John C., Sr.,** Belleville, died August 10, 1986 at the age of 83. Dr. Soucy was a 1929 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

Werelius, Carl Y., Sawyer, Michigan (formerly of Chicago), died July 14, 1986 at the age of 74. Dr. Werelius was a 1940 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Zolt, Nathan,** Park Forest, died April 20, 1986 at the age of 79. Dr. Zolt was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

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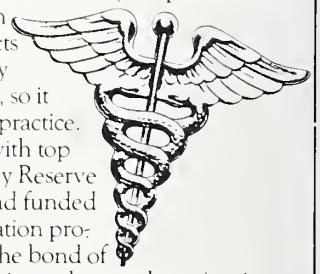
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EKG

(continued from page 193)

Answers: 1. B 2. C, D, E

The twelve lead ECG shows a sinus rhythm at a rate of 60 beats per minute with a normal PR interval of 0.14 seconds and a normal QRS duration. The striking finding on this ECG is the marked ST segment elevation in leads II, III, and AVF with reciprocal ST segment depression in leads I, AVL, and V1 to V3. This current of injury has a vector pointing inferiorly, posteriorly, and rightward, and is compatible with an acute inferior wall myocardial infarction. However, there are no Q waves to confirm the ECG diagnosis of transmural infarction.

Clinically, this patient had relatively mild symptoms without chest pains, but a developing myocardial infarction is still most likely. There was no pericardial friction rub. In pericarditis, the ECG often shows PR segment depression and diffuse ST segment elevation involving limb leads as well as most of the precordial leads. The ST segment vector in pericarditis would then point leftward, anteriorly and inferiorly.

Our patient was admitted to the coronary care unit where serial cardiac enzymes confirmed a myocardial infarction. The ECG evolved as a myocardial infarction but the Q waves that developed were marginally significant.

The patient was treated with nifedipine and timolol. His course in the hospital was uncomplicated. A coronary arteriogram was performed two months later. The left ventricular angiogram showed an area of akinesis in the posterior basal wall compatible with the myocardial infarction. The left coronary system was normal except for some distal nonobstructive plaques in the left anterior descending artery. The right coronary artery was a large dominant vessel with a 50% proximal obstruction and some distal nonobstructive plaques. We speculated that coronary spasm must have played a part in occluding the right coronary artery, causing myocardial damage. His initial ECG with reciprocal ST segment depression suggested a more complicated clinical course. Instead, our patient recovered and started a cardiac rehabilitation program.

Reference

1. J. Nasmith, *et al.*: "Clinical Outcomes After Inferior Myocardial Infarction," *Ann Int Med* 96:22-26, 1982.

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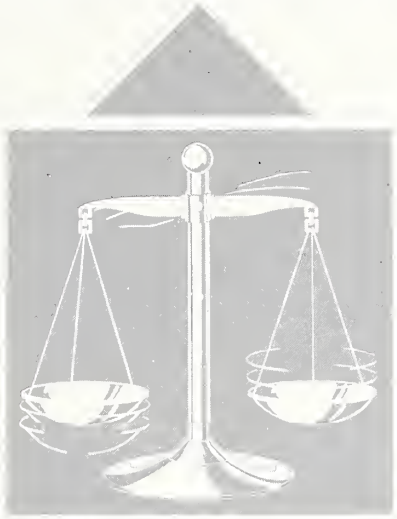
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RESTORING THE BALANCE



Illinois State Medical Society
All-Member Conference
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The Drake-Oakbrook

The ISMS All-Member Conference will provide the knowledge and skills to bring about critical changes in malpractice law this year. Registrants will get the facts they need to persuade legislators and members of the media to support caps on non-economic awards and a revised statute of limitations for minors. A multi-faceted program for the physician as citizen and community leader will encompass:

- A post-election report on the new General Assembly and predictions on its response to legislative initiatives
- Legislative district round-tables to map out grassroots strategy for the 1987 initiative
- Professional media opinion as to how interest groups can influence public policy
- Legislative and allied health professional impact during "sunset" review of the Medical Practice Act
- The new contract review service offered by ISMS at no cost to its members

F. Lee Bailey, one of the nation's foremost defense lawyers, will be the luncheon speaker. He will address the court system in America from the perspective of an experienced litigation attorney.

Physicians and spouses will learn what they need to know as effective citizens and community leaders:

- *How* legislators view caps on non-economic awards in malpractice cases
- *Who* may try to amend the Medical Practice Act and which changes may endanger the integrity of the profession
- *Where* the medical community is most needed in the 1987 battle for malpractice reform
- *What* results can be expected from efforts to pass caps on awards and a revised statute of limitations for minors
- *When* efforts to influence legislators, the public and the media are most effective

Registration materials have been sent to all ISMS and Auxiliary members. Additional information is available from ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. The Society may be contacted by telephone also: (312-782-1654; 1-800-782-ISMS).

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MOUNT CARMEL:
Orthopedic Surgeon, Pediatrician and Family Practitioner—Population 10,000. 64 bed JCAH accredited general hospital, HCA managed, newly built in 1983 replacing a well-established older hospital. Good secondary and high-school and junior college. First year guarantee and other excellent fringe benefits, a lovely river city with several large thriving industries. Any cultural or recreational benefits not provided here are available in nearby large city. Contact: William S. Vokonas, Administrator; Wabash General Hospital, 1418 College Drive, Mt. Carmel, 62863, or phone (618) 262-8621, extension 300. (1)

OAK PARK
Several excellent opportunities immediately available to replace retiring family practice physicians in western suburbs of Chicago. Hospital will provide generous income guarantee, and practice-building and management expertise. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Full time faculty position. Assistant Director of Family Practice center. Responsibilities include teaching in an outpatient setting, monitoring residents, and teaching procedural skills. Some direct patient care. Excellent compensation and benefits. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Two immediate care centers in near west suburbs of Chicago have full and part-time positions immediately available. Opportunity to develop private practice if desired. Hospital will support practice. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Freestanding occupational health centers associated with prestigious community hospital in western suburbs of Chicago have immediate openings for both full and part-time physicians. Excellent compensation. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Growing, 374-bed community hospital in near-west suburb of Chicago seeks board eligible or board certified pediatricians to associate with existing practices. Salary to start, working into partnership. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

PEKIN:
Opened new 20-office multi-specialty physician's medical center attached to Pekin Memorial Hospital, a 202-bed progressive community hospital. Competitive income guarantee and relocation allowance available. Contact: Ruth Campbell, Court and 14th Streets, Pekin, 61554. (1)

SYCAMORE:
Internist with subspecialty interest in rheumatology to join a well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, 60178. (1)

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 170, No. 4
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ISMS Organization

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981. Another milestone was reached in October, 1984, when the headquarters offices relocated to Twenty North Michigan Avenue, Chicago 60602.

The Society published early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. VanDellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938. Illinois also led the way for medical participation in political action when it formed the first medical political action committee, IMPAC, in 1960. The Illinois State Medical Inter-Insurance Exchange, an insurance reciprocal providing comprehensive professional liability insurance for Illinois physicians, was formed in 1976. Concomitantly, Illinois State Medical Insurance Services, Inc., was formed as a wholly-owned subsidiary of ISMS to act as Attorney-in-Fact for the Exchange.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Code of Ethics

WHEREAS, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

WHEREAS, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

RESOLVED, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the Illinois State Medical Society
House of Delegates
November, 1981

Illinois State Medical Society Constitution and Bylaws

Adopted, 1903
As Amended, 1986

Constitution

Article I. Name

The name and title of this organization shall be the Illinois State Medical Society.

Article II. Purposes of the Society

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Society.

Article IV. Composition of the Society

The Society shall consist of active members and such other members as the Bylaws may provide.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

Article VI. Officers

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

Article VII. Board of Trustees

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

Article VIII. Conventions and Meetings

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

Article IX. The Seal

This Society shall have a common seal with power to break, change or renew the same when necessary.

Article X. Amendments

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. Members. Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. Regular Members. Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. Emeritus Members. Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. Retired Members. Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions in the health care field after retiring from medical practice.

D. Service Members. Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. Distinguished Members. Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. In-Training Members. In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. Student Members. Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. Discrimination of Membership. Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. Tenure and Termination.

A. Tenure of Membership. The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be *prima facie* evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. Termination of Membership. Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.*

Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. Reduction and Remission of Dues. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member based upon annual review and recommendation of the component society, for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessments. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.
EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. Composition. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-Elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section, 9) one delegate elected by the Medical Student Section and 10) one delegate elected by the Hospital Medical Staff Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each recognized medical specialty society, as approved by the ISMS Board of Trustees.

Section 2. Delegates. Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. Affiliate Group Delegates. There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. There shall also be a Hospital Medical Staff Section, which shall be comprised of ISMS members elected to represent individual hospital medical staffs. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. Time and Place of Meetings.

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

Section 5. Quorum. Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. Special Meetings. Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. District Division. The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. Order of Procedure. The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. Privilege of the Floor. The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. Introduction of Resolutions and Other Business. All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.
4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions

which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. Judicial Panel. The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. Officers. The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. Elections. All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. Terms of Office. The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. The President-Elect. The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. The Vice Presidents. The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. Successor to President-Elect. In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. The Speaker. The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. The Vice Speaker. The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. The Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. Delegates and Alternate Delegates to the American Medical Association. Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—DuPage County.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. Duties. The duties of the Board of Trustees are executive and custodial.

A. Executive Duties. The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority. The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.
The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. Custodial Duties. The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. Executive Administrator. The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. Meetings. The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. Organization.

A. Chairman. The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. Duties of the Chairman. The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. Quorum. Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. County Societies. The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. Publication. The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. Bonding. The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. Duties of Trustees. Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. Vacancies. If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. The Benevolence Fund. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. Audit and Financial Statement. The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be

assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Physicians elected to district committees shall serve a three year term of office. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. Committee Structure. The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. Councils.

A. The Medical-Legal Council shall be concerned in the areas of:
   1. Liaison with the Illinois Bar Association
   2. Liaison with courts, particularly where impartial medical testimony is involved
   3. Implementation of the Impartial Medical Testimony Rule
   4. Legal aspects of medical practice other than in the area of mental health
   5. Licensing and standards of practice
   6. Quackery
   7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
   1. Federal and state legislation—analysis and communication
   2. Legislative liaison—both state and federal
   3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
   1. Liaison with medical schools, curricula, etc.
   2. Health manpower and training
   3. Internships, residencies, etc.
   4. Scientific assembly
   5. Student loans
   6. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
   1. Ongoing relationships with third parties
   2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
   1. The provision of medical care and health services in the public and private sectors
   2. Emergency medical services
   3. Health care of the poor, aged and those in rural areas
   4. Maternal and child health
   5. Nutrition
   6. Workmen's compensation
   7. Environmental and community health
   8. Rehabilitation
   9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
   1. Publicity and promotion
   2. News media relations
   3. Exhibits and public service programming
   4. Religion and medicine
   5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
   1. Facilities and services
   2. Liaison with Department of Mental Health
   3. Legal aspects of commitment, etc.
   4. Narcotics and dangerous drugs
   5. Alcoholism

Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. Task Forces. A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. Committees Reporting Directly to the Board of Trustees.

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

C. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

D. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

E. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

F. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

Section 6. House of Delegates Committees. House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 7. Organization of House of Delegates Committees.

A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. Board of Trustees Committees. The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the

Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:
   1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
   2. Keep the names of the beneficiaries confidential and known only to the committee;
   3. Recommend the allotment for each recipient; and
   4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:
   1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
   2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
   3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. CME Accreditation Appeal Panel. The panel will consist of seven trustees. It will function as a hearing committee when a CME sponsor appeals a decision of the CME Accreditation Committee. The hearing shall be conducted in conformance with written procedures adopted by the Board of Trustees.

H. The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Chairman of the Finance Committee, and the Immediate Past Chairman of the Board, provided that person is a Trustee.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

J. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

Section 9. Powers of the Board of Trustees. The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon

Section 10. Term of Membership. The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership

in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

Part 1. Component Medical Society. Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

Part 2. District Ethical Relations Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee serving its area function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

Part 3. Offenses.

A. Disciplinary action may be taken against any member of a component society when:

1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
2. He has been adjudged or otherwise recorded as guilty by his component society of:
   a. acts of serious misconduct as a physician; or
   b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

Part 4. Standards and Procedures.

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.

B. Disciplinary action may be initiated by the component society or the ISMS upon receipt of formal written charges filed by any person, alleging violations of any of the offenses enumerated in Part 3 of this chapter. The person filing the complaint may submit it to either the county where the accused physician holds membership or the county where the alleged incident occurred.

Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

Part 5. Penalties. The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to this expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

Part 6. Decision by Component Medical Society.

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical

Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

Part 7. Judicial Panel. A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

A notice of appeal shall be filed with the ISMS Judicial Panel by one of the parties within 30 days after receiving notice of a decision from the component society. Within 15 days after the required filing date for appeal, the party requesting the appeal shall file a written statement with the Judicial Panel which shall include a description of the errors believed to have occurred during the prior proceedings or assertations of the substantive grounds for requesting the Appellate Hearing.

A party may be granted an appeal hearing if: 1) There is reason to believe that procedural error(s) occurred which significantly affected the outcome of the case; 2) There is a showing that those who conducted the initial hearing acted with bias; 3) The evidence upon which the decision was based was not sufficient to support the decision; 4) The evidence was not properly received or considered; or 5) In the sole discretion of the Judicial Panel, there were other reasons which adversely governed the proceedings and denied due process rights to the party requesting the appeal.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws. In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings*, to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

Part 8. Due Process Safeguards. In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW

Part 1. Definitions. Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

Part 2. Component Society Procedures.

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local

option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society or district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:

1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

Part 3. District Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

Part 4. Illinois State Medical Society Procedures.

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1986-1987

Policy Manual of the Illinois State Medical Society

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.
Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

Professional Policies

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Abuse and Neglect of the Elderly

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately.
(1982 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists.
(1975 Annual Meeting—Reviewed by Board, 1980)

Advertising, Physician Professional

See appendix for state law on physician advertising.

(Amended 1985 Annual Meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity, by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged.
(Amended, 1980 Annual Meeting)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.
(1981 Annual Meeting—Reviewed by Board, 1986)

Animals in Research and Education

The Illinois State Medical Society endorses the position that research and medical education, which involves the use of animals, is necessary to enhance the medical care of the public.
(1983 Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds on other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Athletic Performance, Inappropriate Use of Procedures to Improve

The Illinois State Medical Society opposes the use of such items as, but not limited to, hormones, drugs and blood transfusions solely to improve athletic performance.
(1985 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.
(Amended, 1980 Interim Meeting)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additional, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.
(Amended, 1980 Interim Meeting)

Autopsies

Because the autopsy has public health and educational benefits for medical science, the family of the deceased individual and the public at large, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.
(Amended, 1984 Annual Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.
(1971 Annual Meeting—Reviewed by Board, 1986)

Blood Availability

Since the use of a replacement or penalty fee has been eliminated in this state, ISMS encourages component societies to promote the public's full acceptance of the concept of truly altruistic blood donation and community responsibility.

The Illinois State Medical Society and its component societies should strongly encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.
(Amended, 1985 Annual Meeting)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.

The Illinois State Medical Society will attempt to educate physicians and their patients through its publications regarding the inability of contracting AIDS by donated blood. "Designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies.
(Amended, 1984 Annual Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.
(1981 Annual Meeting—Reviewed by Board, 1986)

CPR and First Aid Training for Health Club Employees, Mandatory

ISMS endorses the concept that persons responsible for monitoring or instructing others in health and fitness facilities be certified in basic cardiopulmonary resuscitation.
(1984 Annual Meeting)

Child Abuse

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.
(1981 Interim Meeting—Reviewed by Board, 1986)

Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.
(1981 Interim Meeting—Reviewed by Board, 1986)

Chronic Care Patients

The Illinois State Medical Society encourages medical schools and residency training programs to develop curricula addressing

the issues of utilization of community resources and the strategies for dealing with the long-term medical, rehabilitation and social needs of chronic care patients.
(1984 Annual Meeting)

Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(1981 Interim Meeting—Reviewed by Board, 1986)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness. Section IV of the Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier.
(1976 Interim Meeting—Reviewed, 1981)

Continuing Education

The Illinois State Medical Society shall continue its strong support of voluntary continuing medical education in Illinois and the intra-state accreditation of quality CME programs. Continuing education is one of the basic functions of the Illinois State Medical Society, which is committed to scientific advancement, humanization of medicine, and development of cooperation and rapport with the public.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.
(Amended, 1986 Annual Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services, should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.
(Amended, 1983 Annual Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.
(1977 Annual Meeting—Reviewed by Board, 1986)

Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.
(Amended, 1981 Interim Meeting—Reviewed by Board, 1986)

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians to act in violation of their own personal beliefs, morals and conscience.
(Amended, 1981 Annual Meeting)

Diagnosis Related Groups

ISMS supports the concept that the individual hospital medical staffs' responsibility is to ensure that appropriate quality of care for patients shall not be compromised in the Diagnosis Related Groups (DRG) process.
(1983 Annual Meeting)

DRG Payments and Cost of Procedures

ISMS encourages hospitals to establish a mechanism whereby physicians will have ready access, upon admission of patients, to information about expected DRG payments and charges for hospital procedures.
(1984 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Discrimination Against Physicians

The quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education.
(1985 Annual Meeting)

Drinking Age, Legal

A uniform national legal drinking age of 21 years should be established by all states.
(1984 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1982 Annual Meeting)

Drunk Drivers

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.
(1981 Interim Meeting—Reviewed by Board, 1986)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board, 1986)

Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

The Illinois State Medical Society encourages the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate emergency care at functions where a very large number of individuals are present.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1983 Annual Meeting)

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.
(1966 Annual Meeting—Reviewed by Board, 1980)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

- Accepted ethical standards;
- The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;
- Appropriate Illinois statutory or regulatory requirements.

(Amended, 1981 Annual Meeting—Reviewed by Board, 1986)

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.
(1976 Annual Meeting—Reviewed by Board, 1980)

Fees, Informing Patients of

Where feasible and desirable, physicians should provide patients with information regarding fees and, where practicable, discuss this information prior to providing care.
(1984 Annual Meeting)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting—Reviewed by Board, 1986)

Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.
(1982 Annual Meeting)

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations, shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a state-wide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.
(1977 Interim Meeting)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obliga-

tions and standards of professional conduct.
(Amended, 1986 Annual Meeting)

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.
(1978 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting—Reviewed by Board, 1986)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board, 1986)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured as long as the plan has a demonstrated physician-supported patient care management program in effect.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs for limited license practitioners without direct supervision and responsibility for patient care by a physician licensed to practice medicine in all its branches in Illinois.
(Amended, 1986 Annual Meeting)

Health Insurance, Voluntary Plans

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physicians' charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;
- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and
- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

Health Maintenance Organizations

Every insurance identification card for a health maintenance organization should have the designation, "HMO," clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24-hour telephone number which can be called for payment approval in the event of an emergency.
(1982 Interim Meeting)

Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct.
(Amended, 1982 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board, 1986)

Health Systems Agencies

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting—Reviewed by Board, 1986)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting—Reviewed by Board, 1986)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting—Reviewed by Board, 1984)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either in-patient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.
(1981 Annual Meeting—Reviewed by Board, 1986)

Hospital and Medical Staff Committees

A hospital's medical staff should be an autonomous, self-governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees where the hospital gives the staff authority and responsibility and those where the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, that may or may not include medical staff members.
(1982 Interim Meeting)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. The hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on the medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of the hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

ISMS recognizes it is the right and duty of 1) a medical staff organization to evaluate the credentials of all applicants for medical staff privileges, according to objective, predetermined criteria of acceptability and 2) the hospital governing body to grant privileges to those applicants found acceptable and desirable as members of the medical staff.
(Amended, 1985 Annual Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society shall support physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain a high quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.

A physician's hospital privileges should be based on clinical competency and quality of care.
(Amended, 1985 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.
(1984 Annual Meeting—Reviewed by Board, 1986)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

ISMS continues to support the need for physical examinations of, and updating of immunizations for school children in the State of Illinois on school entry, at 5th grade and 9th grade levels, in keeping with preventive medicine measures presently in existence in the state. Measures to assure compliance of the school health mandates by school districts in Illinois should be maintained.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1984 Annual Meeting)

Impaired Physicians

The Illinois State Medical Society and its individual members should recognize the importance and need to promote, support and participate in state, local and hospital activities to prevent, recognize and overcome impairment among medical students, residents and practicing physicians.
(1985 Annual Meeting)

Indigent, Care of the

The Illinois State Medical Society reaffirms organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for it.

However, personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.
(Amended, 1982 Interim Meeting)

Infants Born with Disabilities, Care and Treatment of

The Illinois State Medical Society urges all Illinois medical staffs to develop and conduct educational programs for their mem-

bers involved in the care of handicapped infants, regarding advances in such care, as well as laws and regulations affecting the delivery of these infants.
(1984 Annual Meeting)

Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.

However, it favors enactment of legislation providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.
(Amended, 1982 Interim Meeting)

Insanity as a Defense

ISMS supports the concept that a person may be found innocent of a crime by reason of having severe mental illness or retardation.

For a person to use insanity as a defense, the severity of the person's mental condition should be shown to exhibit an inability to know the nature of his conduct at the time of the offense, and that he was unaware that the act was wrong and personally or socially destructive to himself or someone else.

Testimony by medical experts on the nature of a person's mental condition should be limited to the diagnosis, mental state and motivation of an individual and not on whether the person is "sane" as determined by legal standards.

A person found innocent by reason of insanity should be provided treatment and ongoing supervision to ensure the public is protected, and when psychiatric treatment can no longer help an individual, who is still considered dangerous, that person should be transferred to a nonmedical facility for further supervision.
(1985 Annual Meeting)

Joint Commission on Accreditation of Hospitals

A "physician" (doctors of medicine or doctors of osteopathy) is defined as one who by education, training, experience, and licensure is able to practice medicine in all of its branches. ISMS encourages the Joint Commission on Accreditation of Hospitals to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals. ISMS urges JCAH to recognize the importance of the medical staff in credentialing and in monitoring the quality of care in the hospital and it encourages the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient.
(1983 Annual Meeting)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.

The Illinois State Medical Society opposes any attempts to change the Illinois Clinical Laboratory Act by exempting commercial laboratories or free-standing laboratories and clinics operated by hospitals from meeting the standards of this act.
(Amended, 1985 Annual Meeting)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting—Reviewed by Board, 1986)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board, 1986)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

It supports the philosophy that all medical education accepted for licensure to practice should be comparable.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.
(Amended, 1982 Interim Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.
(1971 Annual Meeting—Reviewed by Board, 1986)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting)

Medical Psychotherapy

Medical psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

ISMS supports the concept that when federal funds are available to the states, physicians should actively participate in the distribution of these funds.
(Amended, 1982 Interim Meeting)

Medical Staff Participation in Accreditation Activities

Medical staff of a hospital should cooperate to achieve JCAH accreditation of their hospital.
(1982 Interim Meeting)

Medical Staff Participation in Hospital Cost Containment Efforts

Physicians on a hospital's medical staff should encourage and cooperate in efforts to see that hospital care is delivered in the most effective manner without compromising quality.
(1982 Interim Meeting)

Medical Staff Relationship with County Medical Society

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.
(1982 Interim Meeting)

Medical Supplies, In-Flight

The Illinois State Medical Society encourages air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in cardio-pulmonary resuscitation procedures.
(1982 Interim Meeting)

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness, must satisfy the definition of an expert witness that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.
(1977 Annual Meeting—Reviewed by Board, 1981)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting—Reviewed by Board, 1986)

Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.
5. The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determing the delivery of that care. Each hospital or hospital system should establish its own standard of psychiatric care to include the level of care needed by that patient, and should monitor the adequacy of psychiatric care other than frequency of visits.

All physician or other health service provided to the DMHDD, other than that by fulltime employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches and a physician licensed to practice medicine in all of its branches should be required to certify the discharge of any patient from a psychiatric institution.
(Amended, 1986 Annual Meeting)

Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.
(1982 Annual Meeting)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Newborns, Prenatal Development of

The public concern about the macroenvironment's effects on human health should be expanded to include equal concern for a healthy intrauterine environment for the prenatal period of development of each child.
(1984 Annual Meeting)

Nurses-Shortage

The ISMS supports nursing education at all its levels.
(Amended, 1986 Annual Meeting)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.
(1973 Annual Meeting—Reviewed by Board, 1986)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting—Reviewed by Board, 1984)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees. ISMS will take all appropriate action to preserve the confidentiality of records and activities of medical staff committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Sections 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended, 1984 Annual Meeting)

Peer Review

See Chapter XII of the Bylaws.
(Amended, 1983 Annual Meeting)

The Illinois State Medical Society is opposed to review which is not conducted by one's peers. A "peer" is a currently licensed physician, licensed to practice medicine in all its branches, who is experienced in the medical question under consideration and, whenever possible, whose primary practice is in the community involved. The ISMS is opposed to utilization review conducted entirely by telephone or similar communications, with no recourse to review by a physician in the same region of the state, whose practice is in the same specialty.
(1986 Annual Meeting)

Physician-Patient Relationship

The Illinois State Medical Society encourages voluntary health organizations to work with the available local medical communities in providing referral and treatment of cancer patients so that existing physician-patient relationships are not breached.
(1984 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take appropriate action to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(Amended, 1984 Annual Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."
(Amended, 1982 Interim Meeting)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting—Reviewed by Board, 1986)

Professional Associations

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting—Reviewed by Board, 1986)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting—Reviewed by Board, 1984)

Provider Organizations, Exclusive

ISMS should monitor the development of health maintenance organizations, IPAs, preferred provider organizations, and exclusive provider organizations in Illinois and have this information available to assist ISMS members in their relationships with these organizations.
(1984 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board, 1986)

Public Aid

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multispecialty care for Public Aid patients should be made available without extensive justification procedures.
(Amended, 1986 Annual Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Rehabilitation

All physical rehabilitation activities should

be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

(Prior to 1965—Reviewed by Board, 1986)

Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.

(Amended, 1982 Annual Meeting)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.

(1980 Annual Meeting)

Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.

(1980 Annual Meeting—Reviewed by Board, 1986)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.

(1981 Annual Meeting)

Reimbursement, Physician

It is desirable to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems, including but not limited to Usual and Customary or Reasonable (UCR).

(Amended, 1985 Annual Meeting)

Relationship with Third Party Payors

ISMS should provide appropriate guidance, education, and communication between the membership and third party payors.

(Amended, 1986 Annual Meeting)

Risk Management

ISMS supports the policy that: (1) Hospital medical staffs recognize the relevance of hospital risk management programs to help protect the hospital, the medical staff and hospital personnel from unnecessary claims and lawsuits; (2) Risk management activity should not adversely affect the ability of a physician from exercising his legal and professional responsibilities to practice medicine and ensure quality care; and (3) The hospital medical staff should be the primary resource which works with the hospital to establish those elements of risk management which directly affect patient medical care.

(1986 Annual Meeting)

Seatbelt Use

The Illinois State Medical Society supports the voluntary use of seatbelts and other passenger restraint devices as effective methods of reducing injury and death in motor vehicle accidents. It supports state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.

(Amended, 1983 Annual Meeting)

Smoking

The Illinois State Medical Society, as a matter of policy, publicly adopts a vigorous stand against cigarette smoking because it is a major health hazard. The Society will work with other agencies inside and outside medicine to eliminate this contributory cause of death, disability and rising health care cost. ISMS will support appropriate legislative initiatives to communicate the risks of tobacco to all, particularly young people.

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and encourages medical staff action to make hospitals tobacco smoke-free, except for certain areas designated for smoking.

Physicians should refrain from smoking during professional patient visits. Exemplary abstinence during social contacts by physicians and their employees with the public in general is highly desirable. Literature and signs concerning the health hazards of smoking should be displayed in medical offices and other public places over which health care professionals have control.

(Amended, 1985 Annual Meeting)

Surgery, Reconstructive

Reconstructive surgery is surgery which is intended to correct deformities caused by disease or accident.

(Amended, 1985 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.

(1979 Annual Meeting—Reviewed by Board, 1986)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization over and above the judgment of the treating physician.

(1978 Annual Meeting)

Tobacco Farm Subsidies

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.

(1982 Annual Meeting)

Veterans Administration

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.

(Amended, 1980 Annual Meeting)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.

(1978 Annual Meeting—Reviewed by Board, 1986)

Workers Compensation

The Illinois State Medical Society advocates a single radiologic examination to satisfy the medical requirements at a given time in the course of a workers compensation injury.

(1982 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting)

Budgets—(see Financial Policies)

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting—Reviewed by Board, 1986)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting—Reviewed by Board, 1986)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.
(1980 Interim Meeting—Reviewed by Board, 1986)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.
(1980 Annual Meeting)

Dues Stabilization, Membership

The Illinois State Medical Society should 1) carefully consider the delicate balance of dues and membership and 2) maintain reasonable dues within the context of budgetary reviews and long-range planning in order to preserve medicine's strength by member involvement and participation.
(1985 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.
(Amended, 1980 Annual Meeting)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.
(1977 Annual Meeting)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.
(1978 Annual Meeting)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.
(1981 Annual Meeting)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.
(Prior to 1965—Reviewed by Board, 1986)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(Amended, 1982 Annual Meeting)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.
(Prior to 1965—Reviewed by Board, 1980)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.

Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.
(Amended, 1981 Interim Meeting)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Board of Trustees.
(Amended, 1980 Annual Meeting)

Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the Society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.
(Amended, 1981 Interim Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physician's judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board, 1980)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.
(1978 Interim Meeting)

National Library of Medicine

The Illinois State Medical Society supports the programs of the National Library of Medicine. Fees for subscribers should be based on the current accounting system rather than on total costs.
(1982 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors in training in Illinois and to those who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.
(Amended, 1986 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting—Reviewed by Board, 1982)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.
(1980 Interim Meeting)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended, 1980 Interim Meeting)

Resident Physician Membership

Each regular member of ISMS is encouraged to recruit at least one resident physician member every year, with the regular member providing assistance to the resident in completing the application process for membership.

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(Amended, 1983 Annual Meeting)

Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(1979 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Recognized medical specialty societies as approved by the Board of Trustees shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board, 1980)

Policy Manual Appendix

State Regulation on Physician Advertising

The Illinois legislature passed a law to govern advertising by physicians which came into effect as of July 1, 1980. The Illinois Department of Registration and Education, which is responsible for implementation of the law, adopted the following regulations for that purpose on January 26, 1981.

Rule VII. Advertising Permitted

7.01 Any person licensed under the Act may advertise the availability of professional services in the public media, on the premises where such professional services are rendered or by the issuance of business or appointment cards. Such advertising shall be limited to the following information:

a. General information: Name, title, home and office addresses and telephone numbers, answering service, announcement of opening of, change of, absence from or return to business, and announcement of additions to or deletions from professional licensed staff.

b. Professional information: Degrees earned, board certification, areas of specialization, limitation of professional practice, type of practice (individual, group), professional affiliation, hospital affiliation and foreign language competence.

c. Fee information: Usual and customary fees for routine professional services which information shall include notification that fees may be adjusted due to complications or unforeseen circumstances. The usual and customary fee stated shall be that fee charged to the majority of patients seeking the same basic service and shall not be an average charge.

Public media shall include any commercial publication or other form of public communication, including any newspaper, magazine, telephone directory, radio, television or other advertising.

7.02 Advertising shall contain all information necessary to make the communication informative and not misleading. The form of advertising shall be designed to communicate the information contained therein to the public in a direct, dignified and readily comprehensible manner.

If an advertisement is communicated to the public over television or radio, it shall be prerecorded and approved for broadcast by the physician, and a recording of the actual transmission, including videotape, shall be retained by the physician.

7.03 The following types of advertising are prohibited:

a. Advertising by means of testimonials, anecdotal reports of medical practice successes or claims of superior quality of care to entice the public.

b. Advertising fee comparisons of available services with those of other persons licensed under the Act.

c. Advertising professional services which the offeror of such services is not licensed to render.

d. Advertising which contains false, fraudulent, deceptive or misleading material, warranties or guarantees of success, statements which play upon the vanity or fears of the public or statements which promote or produce unfair competition.

e. Advertising by means of display or similar advertising that may serve to mislead or misinform the public.

f. Advertising by solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain.

Effective January 26, 1981.

The Illinois General Assembly amended the original law in 1984, adding prohibitions. Physicians may not:

(1) Advertise that the licensee will accept as payment for services rendered by assignment from any third party payor the amount the third party payor covers as payment in full, if the effect is to give the impression of eliminating the need of payment by the patient of any required deductible or co-payment applicable in the patient's health benefit plan; or

(2) Advertise a fee or charge for a service or treatment which is different from the fee or charge the licensee submits to a third party payor for that service or treatment.

As used in this Section, "advertise" means solicitation by the licensee or through another by means of handbills, posters, circulars, motion pictures, radio, newspapers, television or in any other manner.

Trustee District Committees

First District

David B. Littman, Highland Park, *Trustee*
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
David Clark, Aurora, *Chairman*	1987
Gerald Liesen, St. Charles	1988
A. M. Rossetti, McHenry	1989

Peer Review Committee	
David Helberg, Waukegan, *Chairman*	1987
Eugene Pitts, Waukegan	1987
James Pritchard, Geneva	1987
Peter Vinceguerra, Libertyville	1987

Second District

Ross N. Hutchison, Gibson City, *Trustee*
Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford

Ethical Relations Committee	Term Expires
William Erkonen, Streator, *Chairman*	1989
Julius Kowalski, Princeton	1989
Lawrence D. Lee, Manhattan	1988
Merle Otto, Frankfort	1988

Peer Review Committee	
D.G. Parkhurst, Kankakee, *Chairman*	1989
James B. Aplington, LaSalle	1988
Robert Betasso, Ottawa	1988
Silvio Davito, Spring Valley	1988
Bernard J. Doyle, LaSalle	1988
William Ehling, Streator	1989
Guy Pandola, Joliet	1987
Alex Spadoni, Joliet	1988
Theodore W. Wagenknecht, Streator	1988

Third District

James H. Andersen, Oak Brook, *Trustee*
Richard Blankshain, Oak Park, *Trustee*
Alfred J. Clementi, Arlington Heights, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Joan E. Cummings, Hines, *Trustee*
Harold L. Jensen, Flossmoor, *Trustee*
Arthur R. Peterson, Chicago, *Trustee*
Pedro A. Poma, Melrose Park, *Trustee*
Harry A. Springer, Evanston, *Trustee*
Cyril C. Wiggishoff, Chicago, *Trustee*

Fourth District

Lorris M. Bowers, Peoria, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Jerry Ramunis, Victoria, *Chairman*	1988
Earl Clark, Rock Island	1987
Kenneth Ambrose, Monmouth	1988

Peer Review Committee	
James C. Parsons, Geneseo, *Chairman*	1988
Donald Dexter, Macomb	1989
William Dougherty, Moline	1987
Richard Flacco, Galesburg	1988
G. W. Giebelhausen, Peoria	1987
Clarence Ward, Peoria	1987

Fifth District

Michael C. Snyder, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1989
Jack Means, Mason City	1987
A.L. Van Ness, Bloomington	1988

Peer Review Committee	
Albert Cunningham, Normal, *Chairman*	1989
Robert B. Perry, Lincoln	1988
Donald Yurdin, Springfield	1988

Sixth District

George T. Wilkins, Jr., Edwardsville, *Trustee*

Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Edward K. DuVivier, Alton, *Chairman*	1989
Bernard Baalman, Hardin	1987
C.B. Lara, Pittsfield	1987
Robert Roy, Jacksonville	1987

Peer Review Committee	
Walter Stevenson, III, Quincy, *Chairman*	1989
Robert England, Carlinville	1987
Robert F. Hamilton, Alton	1987
Robert C. Murphy, Quincy	1988
Edward Ragsdale, Alton	1989
James Sutherland, Quincy	1989

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*

Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Delbert H. Hahn, Jr., Decatur, *Chairman*	1988
E. Doyle Slifer, Taylorville	1989
E.F. Stephens, III, Centralia	1988

Peer Review Committee	
H. Gale Zacheis, Decatur, *Chairman*	1989
Ruben Boyajian, Effingham	1989
Clarence G. Glenn, Decatur	1988
D.H. Rames, Vandalia	1988

Eighth District

Eugene P. Johnson, Casey, *Trustee*

Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1989
Stanley R. Huffman, Charleston	1989
Charles L. Lansford, Urbana	1988
James H. Pass, Olney	1987

Peer Review Committee	
George T. Mitchell, Marshall, *Chairman*	1987
Edward S. Warren, Danville	1988
R. C. Adams, Champaign	1988

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*

Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Richard L. Morgan, Marion, *Chairman*	1988
Eli Borkon, Carbondale	1989
Paul Lorenz, Carbondale	1989

Peer Review Committee	
Philip D. Boren, Carmi, *Chairman*	1988
Larry Jones, Harrisburg	1987
Roger Klam, Carbondale	1987
Harry L. Lewis, Benton	1988
Eugene B. Loftin, Fairfield	1988
Charles K. Wells, Mt. Vernon	1988

Tenth District

Thomas P. Meirink, Belleville, *Trustee*

Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1988
Charles Frazer, E. St. Louis	1988
Edilberto Maglasang, Columbia	1988
Wm. A. Simmons, Belleville	1988

Peer Review Committee	
Theodore L. Bryan, Belleville, *Chairman*	1987
Henry Hurd, Belleville	1988
R. W. Jost, Waterloo	1987
R. E. Schettler, Red Bud	1989
Ronald G. Welch, Belleville	1987

Eleventh District

Raymond A. Dieter, Jr., Glen Ellyn, *Trustee*

County of DuPage

Twelfth District

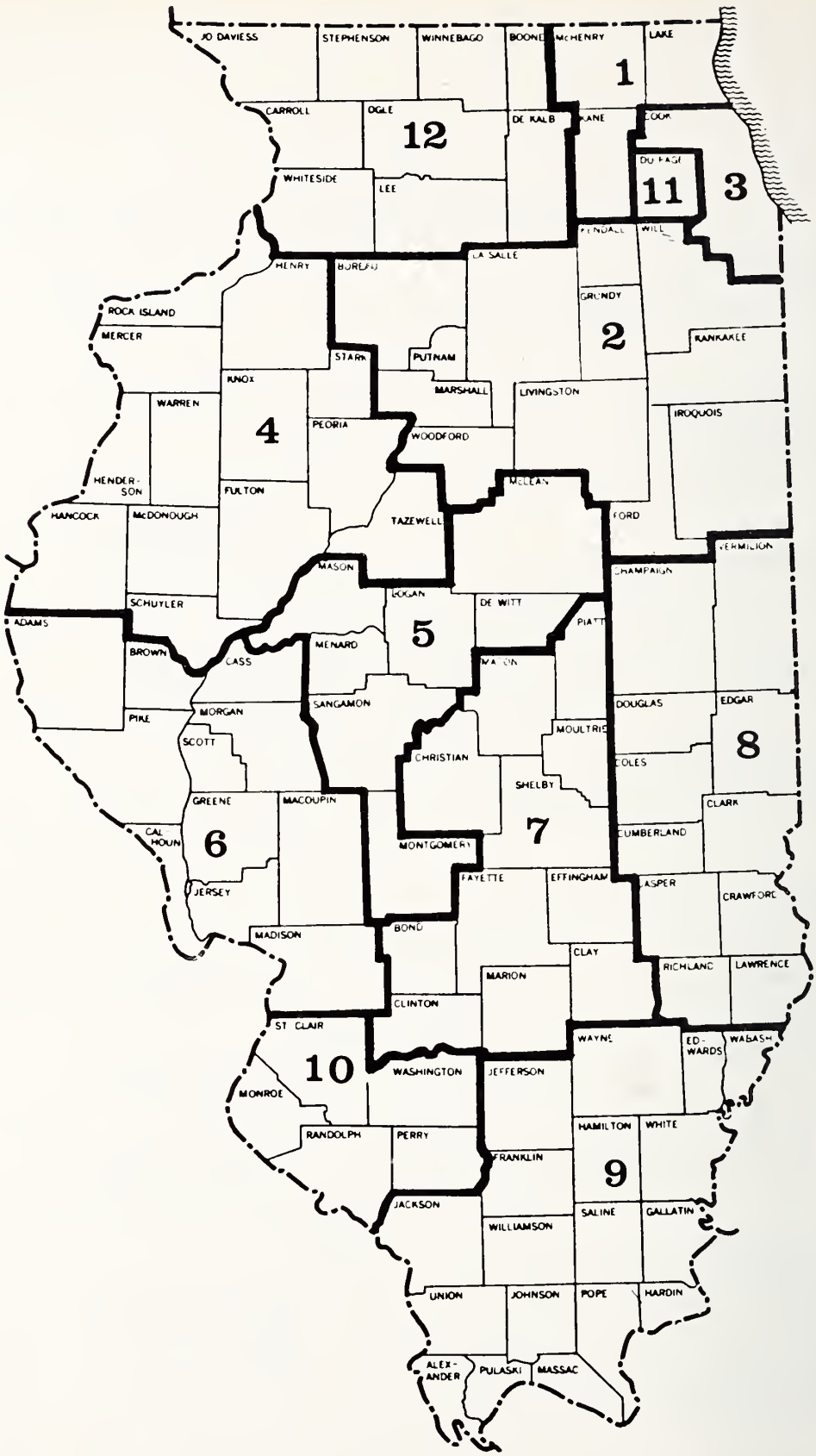
Raymond E. Hoffmann, Rockford, *Trustee*

Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, Belvidere, *Chairman*	1987
David Deets, Dixon	1989
Edward Maglietta, Freeport	1989
Daniel Swift, Rockford	1987

Peer Review Committee	
John H. Steinkamp, Belvidere, *Chairman*	1987
David Deets, Dixon	1989
Edward Maglietta, Freeport	1989
Daniel Swift, Rockford	1987

ISMS TRUSTEE DISTRICTS



1986 Officers of County Medical Societies

County	*Members*	*President*	*Secretary*
Adams	Members: 96-Dist. 6 Maxine Boyer, Ex. Sec., 2039 Sunnybrook, P.O. Box 767, Quincy 62306	John Gollhofer 1416 Main St., Quincy 62301	Richard L. Newman 1225 Broadway, Quincy 62301
Alexander-Pulaski	Members: 5-Dist. 9	Crisostomo Lozada 2020 Cedar St., Cairo 62914	Gemo Wong 529 Cross St., P.O. Box 233, Cairo 62914
Bond	Members: 10-Dist. 7	Boyd A. McCracken, Jr. Health Care Drive, Rural Rt. 3, Box 40 Greenville 62246	Boyd E. McCracken, Sr. Health Care Drive, Rural Rt. 3, Box 40, Greenville 62246
Boone	Members: 22-Dist. 12	Jon Dennis P.O. Box 339, Belvidere 61008	John Steinkamp 824 Van Buren, Belvidere 61008
Bureau	Members: 33-Dist. 2	Rakesh K. Garg 600 E. First, Spring Valley 61362	Edwin L. Johnson 115 Walnut, Box 365, Tiskilwa 61368
Carroll	Members: 8-Dist. 12	Kiran Rabheru 333 Chicago Ave., Savanna 61074	Benjamin Sy 333 Chicago Ave., Savanna 61074
Champaign	Members: 306-Dist. 8 Larry Booth, Ex. Sec., 1408 W. University, Urbana 61801	Robert Brunner 302 E. Stoughton, Champaign 61820	Robert E. Welke Carle Clinic, 602 W. University, Urbana 61801
Christian	Members: 21-Dist. 7	Ziad J. Asali 600 N. Main St., Taylorville 62568	Ignacio Del Valle 311 S. Main, Taylorville 62568
Clark	Members: 5-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 7-Dist. 7	Alva P. Nancy, Jr. 433 E. 7th St., Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
Clinton	Members: 16-Dist. 7	Belan E. Floreza 118 N. Oak, Trenton 62293	James A. Kirby Box 87, 989 Clinton, Breese 62230
Coles-Cumberland	Members: 64-Dist. 8	James McKechnie 103 Professional Plaza, Rural Rt. 4, Mattoon 61938	Sjanna Johnston Tri County Clinic, P.O. Box B, Casey 62420
Cook	Members: 10,146-Dist. 3 Fred Schwartz, Exec. Dir., 515 N. Dearborn, St., Chicago 60610	Pedro A. Poma 675 W. North Ave., #407, Melrose Park 60160	James H. Andersen 141 Breakenridge Farm, Oak Brook 60521

County	*Members*	*President*	*Secretary*
Crawford	Members: 17-Dist. 8	Michael W. Elliott 1002 N. Allen, Robinson 62454	W.B. Schmidt 408 S. Cross St., Robinson 62454
DeKalb	Members: 64-Dist. 12	William S. Kenshol 10 Mechanic St., Sandwich 60548	Richard A. Lane 232 S. Second St., DeKalb 60115
DeWitt	Members: 10-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas	Members: 12-Dist. 8	Grant A. Jones 318 S. Ash, Arthur 61911	Robert Arrol 126 S. Locust, Arcola 61910
DuPage	Members: 813-Dist. 11 Lillian Widmer, Ex. Admin., 800 Roosevelt Road, Building B-Suite 300, Glen Ellyn 60137	Luis E. Cespedes 172 Schiller, Elmhurst 60126	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 12-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham	Members: 29-Dist. 7	Charles W. Runde 206 N. Pear Teutopolis 62467	William S. VanBergen P.O. Box 1268, Effingham 62401
Fayette	Members: 12-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Hans Rollinger 1003 N. Eighth St., Vandalia 62471
Ford	Members: 12-Dist. 2	Ross Hutchison 126 E. 9th St., Gibson City 60936	David J. Hagan 214 N. Sangamon, Gibson City 60936
Franklin	Members: 23-Dist. 9	Harry L. Lewis Benton Medical Center, P.O. Box 639 Benton 62812	Bob G. Thompson The Professional Building 309 W. St. Louis St., W. Frankfort 62896
Fulton	Members: 38-Dist. 4	Jaime Cercone 511 N. Promenade, Havana 62644	Linda Forestier 175 S. Main, Canton 61520
Gallatin	Members: 1-Dist. 9	John E. Doyle Ridgway 62979	John E. Doyle Ridgway 62979
Greene	Members: 9-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid Fillinger Memorial Clinic 712 S. College, Greenfield 62044
Hancock	Members: 10-Dist. 4	Vasant Pawar 216 Parkway Drive, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson	Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark	Members: 31-Dist. 4	Reinart Svendsen, Jr. Arrow Towers, 513 Elliott St., Kewanee 61443	Randall L. Mullin 648 N. Chicago St. Geneseo 61254

County	*Members*	*President*	*Secretary*
Iroquois	Members: 22-Dist. 2	Mohammed M. Razvi Rt. 1 & Rt. 24 East Watseka 60970	Norman D. Hungness P.O. Box 579, Sheldon 60966
Jackson	Members: 96-Dist. 9	Clifford Coleman 306 W. Main, Carbondale 62901	Dale Blaise 215 N. 14th, Murphysboro 62966
Jasper	Members: 2-Dist. 8	Monico Low P.O. Box 377, Newton 62448	Monico Low P.O. Box 377, Newton 62448
Jefferson-Hamilton	Members 43-Dist. 9	Sharad Pangarkar 1907½ Broadway Mt. Vernon 62864	Kenneth Peart #1 Doctors Park Rd., Mt. Vernon 62864
Jersey-Calhoun	Members: 13-Dist. 6	Roger Schroeder P.O. Box 7 Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
Jo Daviess	Members: 11-Dist. 12	Wilbur E. Johnson 219 Summit St., Galena 61036	David R. Smith 219 Summit St., Galena 61036
Kane	Members: 338-Dist. 1 H. Michael Wild, Ex. Dir., 355 First St., Batavia 60510	Thomas R. Huberty 1240 N. Highland Ave., #22, Aurora 60506	Robert K. Dean 123 South St., #240, Geneva 60134
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Lee	Members: 27-Dist. 12	Mary Ann Polascik McNichols Clinic, Ltd., 120 S. Hennepin Ave., Dixon 61021	Tiam H. Lie 425 River Bluff Rd., Dixon 61021
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County	*Members*	*President*	*Secretary*
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Morgan-Scott	Members: 43-Dist. 6	Harvey D. Scott, III 2000 W. Morton Rd., Jacksonville 62650	Richard Fox 1606 W. Lafayette, Jacksonville 62650
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County	*Members*	*President*	*Secretary*
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Perry	Members: 14-Dist. 10	Raghuveer M. Kudva, P.O. Box 425 DuQuoin 62832	John G. Fozard 206 N. Main, Pickneyville 62274
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Pike	Members: 11-Dist. 6	Thomas C. Bunting 321 W. Washington Pittsfield 62363	Ronald Johnson 112 W. Jefferson Pittsfield 62363
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St. Clair	Members: 276-Dist. 10 Adrienne Noubarian, Ex. Dir., 6400 W. Main, Suite 3L, Belleville 62223	Edward P. Rose 5308 W. Main, Belleville 62223	Silvana Menendez 6600 W. Main St., #8, Belleville 62223
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Schuyler	Members: 7-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby	Members: 11-Dist. 7	Urbano Dauz Hickory Point, Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
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County	*Members*	*President*	*Secretary*
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Vermilion	Members: 107-Dist. 8	Bhirom Buranakul 102 N. Logan, Danville 61832	Michael Lomax 917 N. Walnut, Danville 61832
Wabash	Members: 7-Dist. 9	Donna Gambel 1011 Market St., Mt. Carmel 62863	Donna Gambel 1011 Market St., Mt. Carmel 62863
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Winnebago	Members: 464-Dist. 12 Robert Carlson, Exec., Adm., 630 E. Jefferson, Rockford 61107	Gareth A. Eberle 2929 N. Main St., P.O. Box 1867, Rockford 61110	Dennis G. Norem 435 N. Mulford Rd., Rockford 61107
Woodford	Members: 7-Dist. 2	Ronald L. Meyer 401 N. Main St., Roanoke 61561	Ronald L. Meyer 401 N. Main St., Roanoke 61561

No Organized County Society: Cass-Brown, Edwards, Johnson, Menard

Joint County Societies: Alexander-Pulaski; Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

ISMS House of Delegates

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ISMIE Board of Governors Chairman, *Ex Officio*—Fred Z. White, P.O. Box 279, 525 Sweetbriar, Chillicothe 61523

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Newton DuPuy* 1968
David S. Fox* 1979
Robert C. Hamilton* 1985
J. M. Ingalls 1976
Charles J. Jannings, III 1972
Frank J. Jirka, Jr.* 1973
Robert P. Johnson 1984
Fredric D. Lake* 1975
Morgan M. Meyer 1986
Jacob E. Reisch (Honorary)* 1979
Willard C. Scrivner* 1974
P. John Seward* 1980
Joseph H. Skom* 1977
Leo P. A. Sweeney* 1953
Fred Z. White* 1982
Cyril C. Wiggishoff* 1983
George T. Wilkins, Jr., ... 1978
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Maurice M. Hoeltgen, Chicago 1968-1970
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Andrew J. Brislen, Chicago 1973-1975
James A. McDonald, Geneva 1975-1977
Cyril C. Wiggishoff, Chicago 1977-1979
Robert P. Johnson, Springfield 1979-1981
Clifton L. Reeder, Wilmette 1981-1983
Julian W. Buser, Belleville 1983-1985

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Herbert Dexheimer, Belleville, Trustee of the 10th District
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Lawrence L. Hirsch, Northbrook, Trustee of the 3rd District
Eugene Hoban, Chicago, Trustee of the 3rd District
Kenneth Hurst, Naperville, Trustee of the 11th District
Harold L. Jensen, Flossmoor, Trustee of the 3rd District
Eugene P. Johnson, Casey, Trustee of the 8th District
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ISMS Delegation to the AMA

Delegation Chairman: Morgan M. Meyer/Secretary: Robert C. Hamilton

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To serve from Jan. 1, 1985 to Dec. 31 1986 (Elected April 8, 1984)

Audley F. Connor, Jr., Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Northbrook
Michael L. Nieder, Chicago
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park*
P. John Seward, Rockford
Robert M. Vanecko, Chicago**
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

To serve from Jan. 1, 1986 to Dec. 31, 1987 (Elected April 27, 1985)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville****

To serve from Jan. 1, 1987 to Dec. 31, 1988 (Elected April 5, 1986)

James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Lawrence L. Hirsch, Northbrook
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park
Richard Quinones, Chicago
P. John Seward, Rockford
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

Alternates

To serve from Jan. 1, 1985 to Dec. 31, 1986 (Elected April 8, 1984)

James H. Andersen, Oak Brook
James DeBord, Peoria
Manuel O. Guerrero, Moline
Alfred J. Kiessel, Decatur
William J. Marshall, Chicago***
Joseph B. Perez, Rockford
Clifton L. Reeder, Wilmette
Harry A. Springer, Evanston
Robert M. Vanecko, Chicago***
Nancy Zamora, Rockford

To serve from Jan. 1, 1986 to Dec. 31, 1987 (Elected April 27, 1985)

Randall T. Bellows, Chicago
Albino Bismonte, Waukegan
Joan E. Cummings, Chicago
Ulrich Danckers, River Forest
Earl E. Frederick, Jr., Chicago
A. Beaumont Johnson, Elgin
Carlos B. Lara, Pittsfield
Robert M. Reardon, Bloomington****
Joseph H. Skom, Chicago
Warren D. Tuttle, Harrisburg

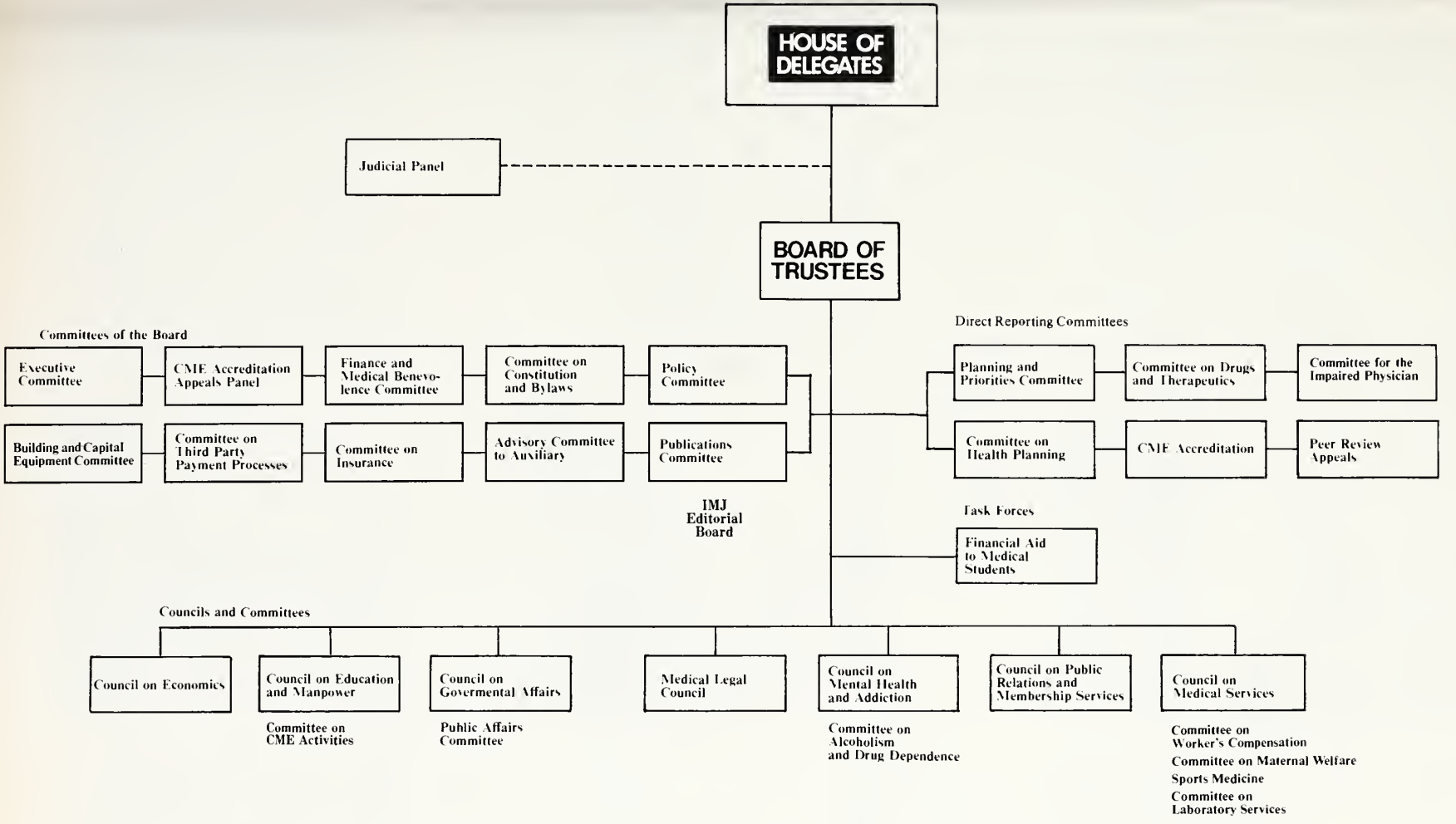
To serve from Jan. 1, 1987 to Dec. 31, 1988 (Elected April 5, 1986)

Juanito S. Bartolome, Jr., Chicago
H. Constance Bonbrest, Chicago
James R. DeBord, Peoria
Manuel O. Guerrero, Moline
Henrietta Herbolsheimer, Chicago
Alfred J. Kiessel, Decatur
William J. Marshall, Olympia Fields
Joseph B. Perez, Rockford
Edie E. Zusman, Chicago

**Elected to 18th position, April 27, 1985*
***Elected April 5, 1986 to complete unexpired term until Dec. 31, 1986*
****Elected April 27, 1985 to complete unexpired term Jan. 1 to Dec. 31, 1986*
*****Elected April 5, 1986 to complete unexpired term until Dec. 31, 1987*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills; John J. Ring, Mundelein



Organizations Directly Related to ISMS

- Illinois Foundation for Medical Care
- Illinois State Medical Benevolent Fund, Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Auxiliary
- ISMS Educational and Scientific Foundation
- ISMS Hospital Medical Staff Section
- Medical Student Section
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society of Medical Assistants
- Ill. Interagency Council on Smoking and Disease
- Ill. Medical Records Assn.
- Illinois Cancer Council
- Citizen's Committee on an Illinois Program to Control High Blood Pressure
- U. S. Pharmacopaeia
- Student Loan Fund Board, ISMS/IAA

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the Board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the Board, as do representatives to various other agencies. The president, speaker of the House, and chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON ECONOMICS

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Maximo B. Baldoza, Hinsdale
Phillip Boren, Carmi
James A. Bull, Silvis
Irene S. Caruso, Galesburg
Patrick E. Ebenhoeh, Chicago
Arvind Goyle, Arlington Heights
William E. Kobler, Rockford
Joseph Murphy, Chicago
Donald K. J. Rokosch, Danville
Gerald E. Silverstein, Chicago
Robert C. Wanless, Belleville

Consultants:
Lorris Bowers, Peoria
Harold Jensen, Flossmoor
Pedro Poma, Melrose Park
Arthur R. Traugott, Urbana
Ronald Welch, Belleville

Resident Representative
Bruce Doblin, Chicago

Student
Rajesh Sinha, Chicago

Auxiliary Representative
Nancy A. Hoffmann, Rockford

Responsibilities and Purposes:

The Council on Economics considers issues that are of direct and immediate economic concern to the practice of medicine in Illinois. The council is interested in effective practice management and the economic impact of governmental health care activities and policies, private health care initiatives, alternative health care delivery systems and the activities of the various utilization review agencies (*i.e.*, PRO, Foundations for Medical Care and private preadmission review initiatives). The council analyzes the impact of these programs, both existing and proposed, and reports its recommendations to the Board of Trustees.

COUNCIL ON EDUCATION AND MANPOWER

Boyd McCracken, Sr., Greenville, *Chairman*
Francois Alouf, Chicago
Bruce C. Becker, Chicago
Michael A. Blood, Cisne
Dean R. Bordeaux, Peoria
H. Constance Bonbrest, Chicago
Daniel G. Cunningham, Chicago
Timothy C. Miller, Peoria
Mitchell L. Rhodes, Chicago
Stephen E. Schubert, Mendota
Edward S. Warren, Danville

Consultants
Lawrence L. Hirsch, Northbrook
William J. Marshall, Olympia Fields
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

Auxiliary Representative
Norma Kiessel, Decatur

Resident Representative
Mike Silver, Oak Park

Student Representative
Dipali V. Apte, Chicago

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R & E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

COMMITTEE ON CME ACTIVITIES

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Robert A. Behmer, Rockford
Robert L. Bertrand, Rockford
Joseph L. Daddino, Chicago
Michael G. Feinzimer, Highland Park
Peter Fried, Lisle
Ronald L. Johnson, Pittsfield

Responsibilities and Purposes:

The Committee on CME Activities serves as the planning and approval body for the Society's continuing education activities. The committee is responsible for identifying educational needs of Illinois physicians, assisting ISMS councils and committees (as directed by the Board or if requested by a committee) in their educational activities, applying for and maintaining ACCME accreditation for ISMS programs, producing programs and materials for medical education directors, and evaluating the application and effectiveness of ISMS CME programs and products in meeting the needs of Illinois physicians.

GOVERNMENTAL AFFAIRS COUNCIL

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Gerald M. Casey, Oak Lawn
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Eugene B. Loftin, Elgin
Paul F. Mahon, Springfield
Terry Mason, Chicago
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Erlo Roth, Hinsdale
Paul R. Stanley, Decatur
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Consultants
James H. Andersen, Oak Brook
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George T. Wilkins, Jr., Edwardsville

Auxiliary Representative
Mrs. Alan (Pam) Taylor, Danville

Student Representative
Mark Dobbertien, Chicago

Resident Representative
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Illinois Medical Group Management Association Representative
Dennis Mock, Chicago

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Paul F. Mahon, Springfield, *Chairman*
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Don E. Hinderliter, Rochelle
Harold Lasky, Chicago
Alan M. Roman, Flossmoor
Richard Schenk, Urbana
Patrick Staunton, Oak Park
Jerome Weiskopf, Rockford

Auxiliary Representative
Mrs. Alex (Patricia) Spadoni, Willow Brook

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

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Susan Balter, River Forest
Alan R. Hirsch, Chicago
James G. Hull, Belleville
Charles A. Janda, Oak Brook
Robert Libman, Chicago
Donal D. O'Sullivan, Oak Park
H. Larry Penning, Decatur
M. Leroy Sprang, Evanston

Consultants
James H. Andersen, Oak Brook
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Raymond A. Dieter, Jr., Glen Ellyn
Morgan M. Meyer, Lombard

Resident Representative
Jonathon Kahn, Chicago

Student Representative
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Auxiliary Representative
Vivian Reardon, Bloomington

Responsibilities and Purposes:

The Council cooperates with all organizations interested in medico-legal problems and educates members of the profession in such affairs. In addition, the Council is concerned with standards of practice, licensure and quackery.

This Council maintains liaison with the Illinois State Bar Association and cooperates with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Evaluator Panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

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William F. Hays, Herrin
Henrietta Herbolsheimer, Chicago
James L. McGee, Decatur
H. Bates Noble, Barrington
Marvin A. Rosner, Chicago
Nunilo Rubio, Chicago
Richard J. Sassetti, Chicago
Dennis Stanczyk, Belleville
Antoinette Thomas, Carbondale

Consultants:
Joan E. Cummings, Hines
Arthur R. Traugott, Urbana
Warren D. Tuttle, Harrisburg

Student Representative
Barry Ticho, Chicago

Resident Representative
Marilyn Feder, D.O., Chicago

Auxiliary Representative
Lynn Kassel, Joliet

IDPH Representative
Bernard Turnock, M.D.

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workers' compensation, sports medicine, and penal health care services.

Committees:

Laboratory Services
Maternal Welfare
Sports Medicine
Workers' Compensation

COMMITTEE ON LABORATORY SERVICES

Antoinette Thomas, Carbondale, *Chairman*
Allan C. Campbell, Peoria
David Duffell, Arlington Heights
Thomas Harwood, Chicago
Gerald G. Hoffman, Lake Forest
C. M. Modi, Chicago
Vincent T. Mosquera, Clarendon Hills
Harold Rothenberg, Chicago
Marshall H. Short, Chicago
Peter J. Soto, Belleville

Consultant:
Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee considers issues and programs pertaining to medical laboratories, blood banking, and related areas affecting the practice of medicine in Illinois; handles matters brought to its attention by the Council on Medical Services; reviews matters related to standards of practice and provides guidance on improving patient care provided via medical laboratories, blood banks, and related entities; works with state agencies on matters relating to medical laboratories, blood banks, and related areas; and oversees ISMS direction to support the provision of blood transfusion services that meet the needs of the patients throughout Illinois, via coordinating activities and discussions with blood hanks.

COMMITTEE ON MATERNAL WELFARE

District Members and Alternates
(alternates in italics)

1. Joseph Burke, Waukegan
Jack M. Miller, Aurora
2. Carl P. Mattioda, Streator
Leo Wrona, Joliet
3. Marvin A. Rosner, Chicago, *Chrmn.*
Linda Holt, Glenview
4. Robert Westefer, Peoria
Jeffrey N. Maurus, Moline
5. Robert C. Kaufman, Springfield
Thomas M. O'Hern, Springfield
6. Lemuel G. Villanueva, Jacksonville
7. Herbert W. Thompson, Decatur
William Van Bergan, Effingham
8. Juan F. Rojas, Danville
9. Allan G. Bennett, Carbondale
10. Rosel Calong, O'Fallon
Steven Mathus, Belleville
11. A. William Schafer, Hinsdale
Thomas R. Eckman, Downers Grove
12. John E. Tillis, Rockford
John T. Leonard, Rockford

Consultants:
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago
Ed Ryan, Palos Park
Bernard Turnock, Springfield
Diane Mertens, Chicago
Richard Gelfand, Evanston

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

SPORTS MEDICINE COMMITTEE

H. Bates Noble, Barrington, *Chairman*
David W. Anzaldua, Peoria
Craig Dean, Libertyville
Henry J. Dold, Arlington Heights
Jeffrey Gilles, Rockford
James A. Hill, Chicago
Robert M. Jarrett, Jr., Rockford
Stephen O. Loyd, Gurnee
Eugene Tanski, Chicago
Edward Winslow, Chicago

Consultants:
Audley F. Connor, Jr., Chicago
Robert C. Hamilton, Chicago

Auxiliary Representative
Suzanne Meirink, Belleville

Responsibilities and Purposes:

The committee conducts programs aimed at improving the recognition and treatment of athletic-related injury and disease; advises junior and senior high school coaches and trainers; works with other groups and organizations involved in sports medicine activities; and provides overall direction to the ISMS Physician Games.

COMMITTEE ON WORKERS' COMPENSATION

E. Richard Blonsky, Chicago, *Chairman*
Richard Geline, Skokie
Henry Gross, Peoria
James LaFata, Springfield
Dominick S. Renga, Chicago
Alberto E. Rodriguez, Oak Park
James W. Ryan, Des Plaines

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the workers' compensation system in Illinois.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Silvana Menendez, Belleville, *Chairman*
Fern E. Asma, Chicago
Helen R. Beiser, Chicago
Brad Colen, Peoria
Andrew Griffin, Chicago
Earl Loschen, Springfield
Thomas Minogue, Urbana
Nelson D. Sanchez, Oak Brook
Edward A. Wolpert, Chicago
L. David Zinn, Chicago

Consultants:
Audley F. Connor, Jr., Chicago
Ulrich Danckers, River Forest
Thomas Meirink, Belleville

Student Representative
Karen Levin, Skokie

Auxiliary Representative
Mrs. Alex Spadoni, Willow Brook

Responsibilities and Purposes:

This council serves as a source of information on mental health matters for ISMS. The council cooperates with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse. It is also concerned with reviewing legislation and regulations related to these fields and provides direction for the ISMS Substance Abuse Education program.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Andrew Griffin, Chicago, *Chairman*
Sam Gaines, Springfield
Ronald Kirschner, Glenview
David Spencer, Springfield

Consultants:
Roalda J. Alderman, Dept. of Alcoholism and Substance Abuse
Daniel Behnke, Dept. of Alcoholism and Substance Abuse

Responsibilities and Purposes:

The committee works closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Jane Jackman, Springfield, *Chairman*
Lawrence Gott, Hoffman Estates
Robert Harrington, Tuscola
Giles R. Locke, Decatur
Richard A. Perritt, Chicago
Clifton L. Reeder, Wilmette
William B. Spriegel, Evanston
John M. Sultan, Glencoe
Virgil L. Williams, Chicago

Consultant Trustees
Ross N. Hutchison, Gibson City
William J. Marshall, Olympia Fields
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Cyril C. Wiggishoff, Chicago

Consultant County Executives
John Hanni, Peoria
Fred Schwartz, Chicago
Lillian Widmer, Glen Ellyn
Madge Williams, Bloomington

Resident Representative
Victor Fernandez, Chicago

Student Representative
William E. Maloney, Chicago

Auxiliary Representative
Sherry Betsill, Springfield

IMGMA Representative
John Robertson, Springfield

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance relationships between the media, public and members of the medical profession; and to retain and recruit members in the Society.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Morgan M. Meyer, Lombard, *Chairman*
Jere E. Freidheim, Chicago
Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The Committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

BUILDING AND CAPITAL EQUIPMENT COMMITTEE

Alfred J. Clementi, Arlington Heights, *Chairman*
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Harold L. Jensen, Flossmoor
Alfred J. Kiessel, Decatur
Ronald G. Welch, Belleville

Responsibilities and Purposes:

The Committee shall review and monitor activities pertaining to the building and capital equipment.

COMMITTEE ON CONSTITUTION AND BYLAWS

Robert M. Reardon, Bloomington, *Chairman*
James H. Andersen, Oak Brook
Lawrence L. Hirsch, Northbrook
Ross N. Hutchison, Gibson City
Michael C. Snyder, Springfield

Responsibilities and Purposes:

The Committee on Constitution and Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

CME ACCREDITATION APPEALS PANEL

Ulrich F. Danckers, River Forest *Chairman*
Alfred J. Clementi, Arlington Heights
Audley F. Connor, Jr., Chicago
Raymond A. Dieter, Jr., Glen Ellyn
Ross N. Hutchison, Gibson City
William J. Marshall, Olympia Fields
Thomas P. Meirink, Belleville

Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

EXECUTIVE COMMITTEE

Alfred J. Kiessel, Decatur, *Chairman*
Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Harold L. Jensen, Flossmoor
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Ronald G. Welch, Belleville

Ex Officio (without vote)
Lawrence L. Hirsch, Northbrook
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, the chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE AND MEDICAL BENEVOLENCE COMMITTEE

Ronald G. Welch, Belleville, *Chairman*
Raymond E. Hoffmann, Rockford
Harold L. Jensen, Flossmoor
Pedro A. Poma, Melrose Park

Auxiliary Representative
Mrs. Louis Tarsinos, Princeton

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the Society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON INSURANCE

Arthur R. Peterson, Chicago, *Chairman*
Allan L. Goslin, Streator
Harold L. Jensen, Flossmoor
Warren D. Tuttle, Harrisburg
Cyril C. Wiggishoff, Chicago

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the program's administrator, Corroon & Black, Inc.

POLICY COMMITTEE

Joan E. Cummings, Hines, *Chairman*
Lorris M. Bowers, Peoria
David B. Littman, Highland Park

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

PUBLICATIONS COMMITTEE

William J. Marshall, Olympia Fields, *Chairman*
Joan E. Cummings, Hines
Ulrich F. Danckers, River Forest
Raymond A. Dieter, Jr., Glen Ellyn
Thomas P. Meirink, Belleville

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, shall review all new accounts prior to acceptance and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Ediz Z. Ezdinli, Kenilworth
Larry C. Gunn, Hinsdale
Eugene J. Rogers, Chicago
Constantine S. Soter, Northbrook
David E. Trachtenbarg, Peoria
Donald D. VanFossan, Springfield
Edward A. Wolpert, Chicago

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Arthur R. Traugott, Urbana, *Chairman*
James H. Andersen, Oak Brook
Alfred J. Clementi, Arlington Hts.
Audley F. Connor, Jr., Chicago
Allan L. Goslin, Streator
David B. Littman, Highland Park

ISIM Representative
Ronald Reucker, Decatur

Ill. Medical Group Mngmt. Assoc. Rep.
Nancy Koch, Chicago

Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its primary responsibility is to interact with the appropriate governmental and private third party reimbursement agencies on matters that require a negotiating role at the Board level. It monitors the activities of the Illinois Department of Public Aid, the Medicare program in Illinois, the CHAMPUS program in Illinois, Blue Cross/Blue Shield, other private insurers and other appropriate agencies whose problems have a significant impact on physician reimbursement. This committee negotiates with those entities under the direction of the Board of Trustees to effect appropriate changes in their policies, procedures and programs.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Donald Pochyly, Hines, *Chairman*
Maruti S. Bhorade, Elmhurst
Ernesto B. Eusebio, Springfield
Julius S. Newman, Aurora
Anthony Sapienza, Chicago
Simon Zivin, Chicago

Consultants:
Allan Goslin, Streator
Harold Jensen, Flossmoor
David Littman, Highland Park

Responsibilities and Purposes:

The committee adopts necessary procedural rules and prescribes forms to be used in the conduct of CME accreditation. It reviews applications and survey team reports for intrastate CME sponsors, and makes decisions on the granting of initial accreditation and continuation of accredited status.

Accreditation Activities

ISMS is approved by the Accreditation Council on Continuing Medical Education to accredit intrastate CME sponsors. An integral part of the program is the site visit, used to gather materials, document and verify that the applicant has met the essentials for accreditation.

Physicians throughout the state, including members of the Board of Trustees, councils, committees and medical educators, function as survey team members to gather the necessary information, interview appropriate individuals and observe local CME activities. The Survey Site Team then makes recommendations to the ISMS Committee on CME Accreditation, which makes the final determinations for approval by the ISMS Board of Trustees.

Accredited Illinois CME Sponsors as of September 1, 1986

Alexian Brothers Medical Center, Elk Grove Village
Augustana Hospital and Health Care Center, Chicago
Belleville Hospital Association for CME (Memorial Hospital, St. Elizabeth Hospital), Belleville
Carle Foundation Hospital, Urbana
Central Community Hospital, Chicago
Central DuPage Hospital, Winfield
Christ Hospital, Oak Lawn
Condell Memorial Hospital, Libertyville
Copley-Mercy CME Consortium, Aurora
Edgewater Hospital, Chicago
Elgin Mental Health Center, Elgin
Elmhurst Memorial Hospital, Elmhurst
Forest Hospital, Des Plaines
Franciscan Medical Center, Rock Island
Glendale Heights Community Hospital, Glendale Heights
Good Samaritan Hospital, Downers Grove
Gottlieb Memorial Hospital, Melrose Park
Grant Hospital, Chicago
Henry Horner Childrens' Center, Chicago
Highland Park Hospital, Highland Park
Hinsdale Sanitarium & Hospital, Hinsdale
Holy Cross Hospital, Chicago
Humana Hospital, Hoffman Estates
Hyde Park Community Hospital, Chicago
American Heart Association (Illinois Affiliate)
Illinois Masonic Medical Center, Chicago
Ingalls Memorial Hospital, Harvey
Institute for Psychoanalysis, Chicago
Jackson Park Hospital, Chicago
Kishwaukee Community Health Center, DeKalb
Loretto Hospital, Chicago
Louis A. Weiss Memorial Hospital, Chicago
Lutheran General Hospital, Park Ridge
MacNeal Memorial Hospital, Berwyn
Martha Washington Hospital, Chicago
Mary Thompson Hospital, Chicago
Mercy Hospital & Medical Center, Chicago
The Methodist Medical Center of Illinois, Peoria
Mount Sinai Hospital Medical Center, Chicago
Northwest Hospital, Chicago
Northwest Community Hospital, Arlington Heights
Norwegian-American Hospital, Chicago
Oak Forest Hospital, Oak Forest
Oak Park Hospital, Oak Park
Prairie Cardiovascular Center, Springfield
Provident Medical Center, Chicago
Ravenswood Hospital Medical Center, Chicago
Resurrection Hospital, Chicago
Riveredge Hospital, Forest Park
Riverside Hospital, Kankakee
Rockford Memorial Hospital, Rockford
St. Anne's Hospital, Chicago
St. Anthonys Hospital, Chicago
St. Anthony Hospital Medical Center, Rockford
St. Elizabeth's Hospital, Chicago
St. Elizabeth Hospital, Danville
St. Francis Hospital, Evanston
Saint Francis Hospital Medical Center, Peoria
St. James Hospital, Chicago Heights
St. Joseph Hospital, Chicago
St. Joseph Hospital, Elgin
St. Mary's Hospital, Kankakee
St. Mary's Hospital, Streator
St. Mary of Nazareth Hospital, Chicago
St. Therese Hospital, Waukegan
Sherman Hospital, Elgin
Shriner's Hospital for Crippled Children, Chicago
Silver Cross Hospital, Joliet
Skokie Valley Community Hospital, Skokie
Springfield Clinic, Springfield
Swedish American Hospital, Rockford
Swedish Covenant Hospital, Chicago
Westlake Community Hospital, Melrose Park
West Suburban Hospital, Oak Park

Accreditation Site Surveyors

The following individuals participate in accreditation activities by serving as site surveyors (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D
Anthony L. Barbato
Lloyd Barr, Ph.D.
Robert L. Bertrand
Ben B. Blivaiss, Ph.D.
H. Constance Bonbrest
Ernst Chester Bone
Dean R. Bordeaux, M.D., M.A.
Bradford W. Claxton, M. Ed.
Alfred J. Clementi
Joan E. Cummings
Joseph L. Daddino
Richard E. Dukes
Sherman Elias
Peter O. Fried
Linda K. Gunzburger, Ph.D.
Robert R. Hartman
Terry F. Hatch
Henri Havdala
Thomas O. Henderson, Ph.D.
Lawrence L. Hirsch
Eugene T. Hoban
Raymond Hoffmann
John M. Holland
Kathryn S. Huss
Ross N. Hutchison
William L. Jackson
Frank J. Jirka, Jr.
Eugene P. Johnson
Marten M. Kernis, Ph.D.
Alfred J. Kiessel
James M. Laidlaw
Howard B. Levy
Paul A. Maxwell, Jr.
Boyd E. McCracken, Sr.
Morgan M. Meyer
Joseph R. O'Donnell
Joseph B. Perez
Mather Pfeiffenberger
Joseph C. Sherrick
Robert C. Stepto
Jacob R. Suker
L.W. Tanner
Sheldon S. Waldstein
Fred Z. White, M.D., M.A.
George T. Wilkins, Jr.
Roger A. Wujek
William H. Young, Ed. D.

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Prabha C. Dosi, Rockford
John S. Hyde, Oak Park
Martin J. Kaplan, Highland Park
Frank K. Leung, Waukegan
Allan Lorincz, Chicago

Consultants:
Joan E. Cummings, Hines
Samuel Enloe, Jr., R.Ph., Decatur
Arthur R. Peterson, Chicago
Robert R. Reardon, Bloomington

Responsibilities and Purposes:

The committee meets periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drug products also are reviewed by the committee.

COMMITTEE ON HEALTH PLANNING

Robert M. Vanecko, Chicago, *Chairman*
Martin E. Bruetman, Palos Heights
Norris R. Dougherty, Rockford
Robert M. Flanigan, Barrington
Albert J. Novotny, Peoria
Mark E. Swislow, Chicago
Constantine J. Tatooles, Evanston

Consultants:
David B. Littman, Highland Park
Michael C. Snyder, Springfield
Harry A. Springer, Evanston

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local health systems agencies. The Committee also monitors health care coalitions in Illinois and reports to the Board on coalition activities.

COMMITTEE FOR THE IMPAIRED PHYSICIAN

L. Michael Newman, Evanston, *Chairman*
C. Clyde Anderson, Moline
Daniel Angres, Lombard
Richard Banta, Rockford
Donald Chatman, Chicago
Violet Eggert, Chicago
Thomas T. Flynn, Mt. Vernon
Charles Frazer, Jr., St. Louis
Lee Gladstone, Chicago
Thomas M. Iannucci, Chicago Heights
Richard Lee, Peoria
James Leonard, Champaign
LeRoy Levitt, Chicago
Michael G. Murphy, Belleville
Richard L. Newman, Quincy
Homer Parkhill, Pontiac
Reinhold Schuller, Kankakee
Donald Sellers, Des Plaines
Craig Showalter, Chicago
W. David Steed, Hinsdale
Herbert Trace, Evanston
William J. Weigel, Aurora
James West, Rolling Meadows

Consultants:
Lorris Bowers, Peoria
Raymond E. Hoffmann, Rockford
Warren D. Tuttle, Harrisburg

Resident Representative
Debra Klamen, Chicago

Responsibilities and Purposes:

The Committee for the Impaired Physician consists of physicians who provide assistance to impaired physicians and those concerned about them for problems related to alcohol or drug dependence, physical disabilities, mental or emotional disturbances. The Committee provides information, sponsors educational programs, offers counseling, conducts interventions, provides monitoring and serves as the recovering physician's advocate. All activities are provided in a confidential and professional manner.

PEER REVIEW APPEALS COMMITTEE

Boone Brackett, Oak Park
Henri S. Havdala, Chicago
Harry L. Lewis, Benton
John P. McGee, Glenview
James Russell, Downers Grove

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the state Society's liaison to local peer review committees and monitors review activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Allan L. Goslin, Streator, *Chairman*
Raphael Z. Campanini, Chicago
Raymond E. Hoffmann, Rockford
Harold L. Jensen, Flossmoor
John W. Mason, Oak Lawn
Ronald G. Welch, Belleville
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The president-elect shall serve as the chairman of the Committee on Planning and Priorities. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the president-elect in the formation of his objectives for accomplishment during his term as president.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*
George Beranek, Chicago
Julian W. Buser, Belleville
Morgan M. Meyer, Lombard
Karl W. Scheribel, Arlington Hts.
Cyril C. Wiggishoff, Chicago

Auxiliary Representative
Diane Hinderliter, Rochelle

Responsibilities and Purposes:

The Task Force on Financial Aid to Medical Students shall be responsible for developing and maintaining a student loan program through the Educational & Scientific Foundation to assist Illinois medical students in meeting financial obligations of an undergraduate medical school program. In particular, this Task Force shall explore ways and means of raising funds for the development of a student loan program and, through the ISMS Educational and Scientific Foundation, establish guidelines and administration for such a program.

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Frank B. Norbury, Jacksonville, *Chairman*	1988
Donald W. Aaronson, Chicago	1987
Arthur R. Fischer, Berwyn	1989
Jack L. Gibbs, Canton	1991
Robert H. Lund, Rockford	1990

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack L. Gibbs, Canton, *Chairman*
Carl Campanella, Du Quoin
Karl W. Scheribel, Arlington Heights

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

ISMS REPRESENTATIVES TO OTHER GROUPS

Swanberg Foundation, Quincy
Robert R. Hartman, Jacksonville

Liaison to Ill. Soc. of Med. Assts.
Robert R. Hartman, Jacksonville

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

Illinois Medical Records Assoc.
Clifton Reeder, Wilmette

Illinois Cancer Council
Peter Friedell, Chicago

Citizens Committee for an Illinois Program to Control High Blood Pressure
David Berkson, Chicago

U.S. Pharmacopaeia
Vincent Costanzo, Chicago, *Delegate*
Joseph Skom, Chicago, *Alternate*

ISMS SERVICES

Members of the Illinois State Medical Society benefit from a wide range of services, programs, and publications. These are developed in response to official actions and policies of the House of Delegates and implemented through the Board of Trustees. The headquarters staff has been structured to respond to the directives of the House and the Board and develops and coordinates activities to provide these services. Following is a brief description of the divisional structuring, organization and services of the Society and the headquarters office.

EXECUTIVE OFFICE

Mr. Alexander R. Lerner is Executive Administrator of the Society. The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. In this position, the Executive Administrator:

- provides liaison with the Board of Trustees and implements their actions
- is responsible for support and staffing of the House of Delegates
- evaluates legal inquiries for appropriate referral to counsel
- has final authority for management team program planning and implementation
- provides guidance to officers, trustees, committee chairmen and county society officers
- directs activity and organization of staff personnel
- serves as secretary-treasurer for the Illinois State Medical Insurance Services, Inc.

Society programs, issues and activities are coordinated administratively through delegation of managerial authority.

ADMINISTRATION

The Deputy Administrator, Administration, directs and manages activities of the Divisions of Specialty Society Services and Administrative Records. Additionally, direct staff support is provided through the Deputy Administrator for the House of Delegates, Board of Trustees, Executive Committee, Policy Committee, Constitution and Bylaws Committee, the Educational and Scientific Foundation, the Medical Student Section and the Resident Physician Section. Overall provision of services of staff are coordinated through the Deputy Administrator. The Deputy Administrator reports directly to the Executive Administrator and assumes additional responsibility at the direction of the Executive Administrator.

Administrative Records

The Division of Administrative Records is charged with responsibility for maintaining the listing of official actions and positions taken by ISMS' House of Delegates and Board of Trustees. The minutes and official transcriptions are maintained by this Division. In addition, records of all appointments and nominations are kept, as well as any other official documents.

Services to Specialty Societies

Administrative services are provided to specialty societies and affiliated groups on a cost-allocated basis by the Division of Specialty Societies. These include office management, meeting arrangements, membership promotion and record maintenance, newsletter publishing, coordination of committee work, dues collection and accounting services.

FINANCE AND MANAGEMENT SERVICES

The Associate Administrator, Finance, is responsible for the direction of the financial management activities, computer services, meeting services, membership programs, sponsored insurance programs, the benevolence fund, office services and human resources management. This group is responsible for management of the physical premises occupied by the Society and maintains liaison with the various auditing firms.

Financial Management

Financial Management services are conducted under policies established by the Board of Trustees and Finance Committee. These activities include financial reporting, maintaining financial records for receipts and disbursements, budgeting, monitoring investments and securing assets.

Computer Services

As an integral part of financial manage-

ment, electronic data processing capabilities are maintained to provide a cost-effective method to:

- maintain membership and policyholder records;
- provide central Society dues billings and collection for county medical societies;
- provide invoicing for professional liability premiums;
- maintain records and statistics on professional liability claims, policyholder files and other insurance related information;
- process financial records and;
- provide word processing capabilities.

Human Resources

The ISMS Human Resources Division is responsible for staffing for the Society, employee benefits program, payroll, employee evaluation and review program, maintenance of all personnel files and the administration of all employee services.

Meeting Services and Membership Programs

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-Year-Club, physician recruitment, meeting services and travel programs.

- The 50-Year-Club consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- ISMS meeting services include provision of services for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- Society-sponsored travel programs enable members to enjoy luxury cruises and tours. Qualified tour agencies are screened for professional, non-regimented trips.

ISMS conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

- The Physician Recruitment Program seeks to link communities in need of a physician with those seeking practice opportunities.

Office Services

Office services includes building services for staff and physician meetings, mail and supply services for the Society. Facility maintenance and centralized purchasing are also under the office service function.

Sponsored Insurance Programs

Staff services are provided for the ISMS Insurance Committee which works through an independent broker as directed by the Board of Trustees, in sponsoring various insurance programs for the benefit of the membership. Each program has been scrutinized for quality and economy. A brief synopsis of each program follows:

Group Term Life Insurance

The group term life insurance program is underwritten by the North American Company for Life and Health Insurance. It offers:

- $25,000 to $1 million in level term life insurance
- a built-in waiver of premium
- availability to members, their spouses and employees under age 65
- coverage to $5,000 for members' children
- non-cancellable, guaranteed renewability to age 100
- conversion to permanent individual policy guaranteed to age 65.

Group Disability Income Protection Program

The group disability income protection program is underwritten by the Commercial Insurance Company. It provides:

- $500-$3,000/month for total disability
- coverage renewable to age 70
- benefit period options of lifetime accident and sickness
- payable (1) to age 65; (2) for seven years; (3) five year accident and sickness payable for 2 years
- available to members and authorized employees or insured members to age 55
- benefits payable regardless of other insurance
- no restrictive riders attached after issuance
- individual coverage cannot be terminated.

Professional Overhead Expense Plan

This plan is underwritten by the Hartford Accident and Indemnity Company and provides:

- $500-$5,000/month coverage
- office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
- benefits payable to 24 months regardless of other insurance
- accumulation benefit provided
- guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
- available to all members under age 65 in full time practice
- rent, utilities, employee salaries and monthly *pro rata* of specified annual fixed expenses customary to the profession
- premiums deductible for individuals and partnerships under Revenue Ruling 55-264.

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

Group Major Medical

The group major medical plan is underwritten by Commercial Insurance Company. It provides that the insured select a calendar year deductible of $500, $1,000 or $2,000 which applies to each insured person. It will then pay 80% of reasonable and customary expenses such as:

- semi-private room in the hospital
- hospital supplies and services, physician services, anesthetists, diagnostic lab and X-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan has a maximum out-of-pocket expense of $4,000 plus deductible and pays up to a lifetime maximum of $1 million on health benefits. The plan is available to all members and qualified employees of insured members under age 55, and can be renewed up to age 65.

Medicare Supplement

The Medicare supplement plan is underwritten by the Hartford Accident & Indemnity Company. It covers charges for the following, incurred either as in-patient or out-patient:

- annual Medicare deductibles
- semi-private room and board
- diagnostic X-rays, lab tests, doctor's services, general nursing, drugs, anesthesia and many other hospital, medical and surgical services which are partially covered by Medicare.

The plan is available to members 65 and over and once members are enrolled, their spouses may be insured on reaching age 65. Eligible applicants are guaranteed acceptance subject to a pre-existing condition limitation.

Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of $27.50, $55.00, $110.00 or $165 per day of hospital confinement. Benefits are also:

- initiated with first day of confinement
- payable to 365 days for each cause of confinement
- automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
- payable regardless of other insurance.

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

Workers' Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insur-

ance Group, are administered under the Dodson Savings Plan. Specific aspects include the following:

- return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
- rates standard and approved for class of employment
- savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits.

Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

- for members, their spouses, children and employees
- a 24-hour business and pleasure coverage from $25,000 to $250,000
- renewable to age 70.

PLANNING AND PROGRAM DEVELOPMENT

The responsibilities of the Associate Administrator for Planning and Program Development are designed to coordinate and execute a broad range of programs across divisional and organizational lines. These responsibilities include:

- provide staff support for the Planning & Priorities Committee and identification of major issues affecting physicians in their practice;
- develop programs that meet the informational needs for the physician membership and the public on the position of ISMS on important medical issues; and
- provide consultation and coordination to ISMS divisions and affiliated organizations on planning and program development.

In addition, the Associate Administrator for Planning and Program Development oversees and coordinates the activities of Educational and Medical Services and Professional Relations.

Educational and Medical Services

The Division of Educational and Medical Services is responsible for initiating, supporting, monitoring and implementing activities related to CME accreditation, alcohol and drug addiction, aging, emergency medical services, blood banking, licensure and accreditation of health care facilities, physician licensure and discipline, school and child health, medical education, medical-legal issues, sports medicine, public health, mental health, peer review, ethics, laboratory services and CME activities.

These responsibilities are carried out through the following activities:

- council and committee meetings, where physician members, and representatives of the medical students, residents and ISMS Auxiliary examine, debate and formulate ideas and recommendations for consideration by the ISMS Board of Trustees;
- development of educational materials and programs for the physician and his or her patients; and
- liaison activities with governmental, professional and lay organizations, to promote and defend ISMS policies, express concerns and educate others about issues important to physicians.

The Division of Educational and Medical Services also administers the following specialized programs:

- ISMS Physician Games, where physicians and spouses compete in athletic competitions;
- The Substance Abuse Education Program, funded by a grant from the Illinois Department of Alcoholism and Substance Abuse, which produces educational materials and seminars to assist physicians in recognizing and treating substance abuse in their patients;
- Maternity morbidity and mortality reviews, funded by a grant from the Department of Public Health;
- ISMS Student Loan Fund Programs, directed by the Task Force on Financial Aid to Medical Students, and funded by the contributions to the Educational and Scientific Foundation;
- Impaired Physician Program, which provides assistance to medical staffs, impaired physicians and their families in situations where alcohol, drugs, senility, disability or other problems prevent a physician from functioning;
- The Physician Support Group, which provides assistance to physician families in dealing with the confusion and stress accompanying involvement in a malpractice action; and
- The Physician Help Line, a confidential phone service, which connects troubled physicians and their families with the above mentioned services and resources.

Professional Relations

Professional Relations provides staff support for the Illinois State Medical Society Auxiliary, the Resident Physicians Section, and the Medical Student Section. It also provides additional support to the Deputy Administrator, Administration, and the Associate Administrator for Planning & Program Development for the Illinois Delegation to AMA, and the Associate Administrator, Finance, for the ISMS Benevolence Fund.

COMMUNICATIONS

Under direction of the Assistant Administrator, Communications, the membership, marketing, field services, public relations and publications activities are coordinated. Staff in these areas:

- provide information on a broad range of issues that affect physicians in their practices;
- provide information to the media and public on the position of ISMS on important medical issues;
- provide consultation and coordination to other ISMS divisions in the area of membership mailings, and distribution of membership and public information;
- provide information and services to hospital medical staffs;
- retain, recruit, promote and process membership in organized medicine at the county, state and AMA levels;
- educate physicians on the professional liability climate in general, and on the value of the Exchange in particular; and
- provide information and coordinate programs for the ISMIS Loss Prevention Committee.

Field Services

Staff in this area:

- provide assistance and information to ISMS members on a broad range of issues by working with district trustees, county medical society leaders and executives, hospital medical staff leaders and ISMIE Network Representatives;
- coordinate the ISMS President's Tour, in which the president visits county medical society meetings and local media to discuss Society views and activities;

- provide staff support to the ISMS Hospital Medical Staff Section;
- publish *Trustee Report,* a newsletter issued periodically which communicates important information on ISMS activities to local physician leaders; and
- promote and assist member activity to further ISMS legislative and governmental goals, including participation in IMPAC and the Key Contact program.

Publications

Staff of the Division of Publications work to provide information to the ISMS membership through various publications. Services include promotional design and layout, editorial and creative work for such publications as:

- The *Illinois Medical Journal* which is published monthly to keep members aware of clinical, economic, legal, and political events;
- *Action Report* which is published periodically to inform members of Society activities and present news in the area of socio-economics;
- *On the Legislative Scene* which is distributed on request to ISMS members during the General Assembly session to offer a status report on pending legislation of importance to Illinois physicians.

Society staff members produce several publications for the Illinois State Medical Inter-Insurance Exchange, including:

- *Exchange Commentary* which serves as ISMIE's main method of communicating with its policyholders;
- *Antidote* which is published jointly with the ISMIS Loss Prevention Committee and discusses case studies designed to help physicians avoid the situations that can lead to malpractice suits; and
- The ISMIE *Annual Report* which presents end-of-year financial data and operating statistics to Exchange policyholders.

ISMS staff assists specialty societies and other affiliate groups in producing their newsletters and other publications. Assistance also is provided to the ISMS Auxiliary in the publication of *Pulse of the ISMS Auxiliary.*

Activities of the Division are directed by the Society's Publications Committee and the *IMJ* Editorial Board. Additional publication production services are provided for subsidiary organizations.

Public Relations

The ISMS Public Relations Division provides information to news media representatives and the public on health care issues. Building the visibility and image of Illinois' medical profession is the division's overall goal. Its activities include regular, frequent development of:

- news releases and related media information voicing ISMS public policy views;
- speeches for use by Illinois physicians in making presentations to a variety of public audiences;
- "white papers," viewpoint essays and brochures on key health care issues;
- public service announcements for broadcast by Illinois radio and television stations; and
- public information resource materials for use by county medical societies.

On a daily basis, the Public Relations Division handles all ISMS media requests and monitors coverage of health care-related topics by Illinois media outlets. Staff is also available to conduct spokesperson training workshops for those physicians speaking out on behalf of ISMS. The division provides services and programming for the Council on Public Relations and Membership Services.

GOVERNMENTAL AFFAIRS

The Division of Governmental Affairs, under direction of the Assistant Administrator for Governmental Affairs, provides staff services for the Governmental Affairs Council, Public Affairs Committee, IMPAC, and liaison to various governmental agencies. The Society's legislative program is conducted under direction of the Governmental Affairs Council. All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. Legislative representatives express the ISMS position to legislators, while also continually monitoring amendments to bills of interest to the medical profession. The Division also coordinates physician testimony before legislative committees.

Additional input and citizen involvement are developed through the Key Contact Program and public affairs activity.

- The Key Contact Program is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators, who advise legislators on health legislation.
- Public Affairs activity includes sponsorship of speakers at Society meetings and liaison with government agencies. It encourages grassroots involvement in the political process. Also, the Division coordinates activities of the Illinois State Medical Society Political Action Committee.

Staff services are provided through both the Chicago headquarters and the Springfield regional office.

HEALTH CARE FINANCE

Under the direction of the Assistant Administrator for Health Care Finance, the Division of Economics and the Division of Health Policy Research are involved in developing programs, policies, services and strategies to address the economic issues impacting the profession. Staff services are provided to the Council on Economics, the Committee on Third Party Payment Processes, the Committee on Health Planning and the Committee on Drugs and Therapeutics. Services are provided to members with questions or problems concerning health care economic issues and research.

Additionally, staff in this area maintain liaison with all appropriate professional associations and ancillary health economic organizations.

Staff in this area provide the following specific services:

Economics

- Medicaid, Medicare & CHAMPUS—Services are provided in representation of member interests of a policy nature. Liaison is provided with Illinois Department of Public Aid and the Medicare Part B Carrier to assure that member concerns are represented when policy issues are

considered. Specific assistance is provided for members with inquiries about third party payor policies.

- Health Planning—Actions of Statewide Health Coordinating Council, Illinois Health Facilities Planning Board, and local Health Systems Agencies are closely monitored and Society positions expressed.
- Third Party Payor and Economic Activity—The Division is directly involved in liaison activities with insurance carriers and government bodies on all economic issues relating to the practice of medicine, *e.g.*, hold harmless agreements and determinations of medical necessity. The Division performs research, offers speakers and monitors the development of new reimbursement and health care delivery systems for the membership, *e.g.*, Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Utilization Review (Private and Peer Review Organizations [PROs]) and HMOs/IPAs.
- Drugs and Therapeutics—The Division provides staff assistance to the ISMS Committee on Drugs and Therapeutics, which reviews new drug products and makes recommendations to the Department concerning products for inclusion in the IDPA Drug Manual for Public Aid recipients.
- Office of Contractual Services—ISMS provides free of charge to any member a summary of the major terms and conditions of proposed PPO, HMO, and IPA contracts. The summary does not advise physicians to sign or not sign such contracts, nor is it intended to provide specific legal advice. However, the summary explains in detail the major terms and conditions of proposed PPO, HMO, and IPA contracts. Further, the impact of the contracting provisions on a physician's professional liability insurance is stressed. Members wishing such a review may submit two copies of the proposed contract and any documents incorporated by reference (*e.g.*, bylaws, UR agreements) to the ISMS offices.

Health Policy Research

- Health Data Systems—Governmental requirements for statistical information on health care and planning are monitored and commented upon.
- Research Development—Rules and regulations proposed by various state code departments (IDPA, IDPH, DOI, CMS) and federal agencies (HCFA) are researched, monitored and commented upon to ensure that ISMS concerns about policies and procedures that impact the practice of medicine are considered prior to implementation or adoption. The Division also reviews all pertinent Federal and Illinois registers, and proposed legislation for possible comment and action, provides statistical analyses for the leadership on health economic issues, serves as a vehicle for health economic research and maintains liaison within the federation concerning development of various strategies on health economic issues (RVS, statewide IPA, HMO).
- Cost Containment—The cost containment activities of various health care entities are monitored, such as the activities of the Illinois Hospital Services Procurement Advisory Board and the Illinois Health Care Cost Containment Council. Additionally, the Division provides Medical Society comment and input on the activities and programs of the Illinois Health Care Cost Containment Council.

DIRECTORY OF MANAGEMENT STAFF PERSONNEL

The Illinois State Medical Society headquarters office is located at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. The telephone number is (312) 782-1654. In addition, a Springfield office is maintained at 701 South Second Street, Springfield, Illinois 62704, telephone (217) 528-5609.

Below are the key staff identified by managerial areas in keeping with the above itemization of responsibilities. Following the name of the individual is a direct dial telephone number at the headquarters office. Any staff member can also be reached through the general information number (312) 782-1654.

EXECUTIVE OFFICE

Alexander R. Lerner, Executive Administrator 580-2412

ADMINISTRATION

Richard A. Ott, Deputy Administrator 580-2460
Rose Anne Christiansen, Director, Administrative Records 580-2470
Leslie Freeman, Director, Specialty Society Services 580-2480

FINANCE AND MANAGEMENT SERVICES

Lawrence Deidrick, Associate Administrator 580-2420
Elizabeth Duffy, Director, Meeting Services and Membership Programs 580-2472
James Giese, Director, Finance 580-2454
Diana Role, Director, Computer Services 580-2488
Alan Allphin, Director, Internal Audit 580-2432
Debra Nelson, Director, Human Resources 580-2430

PLANNING AND PROGRAM DEVELOPMENT

Donald A. Udstuen, Associate Administrator 580-2418
Cheryl Koos, Assistant Director, Professional Relations 580-2493
Larry Boress, Director, Educational and Medical Services 580-2435

COMMUNICATIONS

Linda Hudson, Assistant Administrator 580-2449
Suzanne W. Nelson, Director, Public Relations 580-2423
Gary Fitzgerald, Director, Field Services 580-2474
Martin Masel, Field Representative 580-2473
Daniel R. Nash, Field Representative 580-2411
Mariann Stephens, Director, Publications 580-2419

GOVERNMENTAL AFFAIRS

Jeffrey M. Holden, Assistant Administrator 580-2440
James Tierney, Deputy Assistant Administrator 580-2484
Springfield Regional Office 217/528-5609

HEALTH CARE FINANCE

Robert K. Burger, Assistant Administrator 580-2462
Ken Ryan, Director, Economics 580-2491
Andrew Melczer, Director Health Policy Research 580-2468

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Morgan M. Meyer, Lombard, *Chairman*
Alfred J. Kiessel, Decatur
Allan L. Goslin, Streator
Jere E. Freidheim, Chicago
Harold L. Jensen, Chicago

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a Board of Directors.

IFMC Board of Directors

Joseph Sherrick, Chicago, *President*
Robert P. Johnson, Springfield, *Vice-President*
James Laidlaw, Champaign, *Secretary-Treasurer*
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Lawrence L. Hirsch, Northbrook
Robert Prentice, Springfield

Illinois Society of Medical Assistants American Association of Medical Assistants

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society of Medical Assistants, an affiliate of AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel courses, regional seminars, annual symposium, and personal development day. The annual three-day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year. Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. For further information about this program contact the American Association of Medical Assistants, 20 North Wacker Drive, Chicago, Illinois 60606.

The president of the Illinois Society of Medical Assistants communicates via the "Executive Memo" (a monthly publication), with over 400 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on education topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the Association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for nonmembers. There are many other benefits available (*i.e.*, group insurance). AAMA holds five regional conferences (mini-conventions) at various sites in the country each year. A variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park); DeKalb (Sycamore); LaSalle; Macon (Decatur); McLean (Bloomington); Peoria; Rock Island; St. Clair (Belleville); Spoon River Valley (Canton) and Vermilion (Danville). Physicians in these areas are asked to encourage their medical assistants to join the Association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

If there are no Illinois Society of Medical Assistant Chapters in your area, at-large

memberships are available. Information on the formation of new chapters may be obtained from: Mary Lu Ostroski, CMA, 1704 East Jackson Street, Bloomington, IL 61701 or Ehlma Garcia, CMA, EMT-A, 6134 South Tripp, Chicago, IL 60629.

Officers

President: Mary Lu Ostrowski, CMA, Bloomington
President-Elect: Cheryl Hutchison, CMA, Granite City
Immediate Past President: Ehlma Garcia, CMA, EMT-A, Chicago
1st Vice President: Catherine M. Hill, CMA, Palatine
2nd Vice President: Rebecca Matteson, CMA, EMT, Canton
Recording Secretary: Marjorie Goldasich, Peru
Membership Secretary: Linda Harp, CMA, Granite City
Corresponding Secretary: Bernyce Carbery, Normal
Treasurer: Mary Frances Burton, Chicago
Speaker of the House: Betty Kronemeyer, CMA, Mascoutah
Vice Speaker of the House: A. Ruth Thompson, CMA, Decatur
Chairman, Board of Trustees: Anna Cannon, EMT-A, Chicago
Parliamentary Advisor: Snyobia Payne, Chicago
Chaplain: Darlene Van Dyke, Chicago
Historian: Julie Stoffregen, CMA, Schaumburg
Physician Advisor Chairman: John L. Wright, M.D., Bloomington

Physician Advisors

John L. Wright, M.D., Bloomington, *Chairman*
Jack Chandler Berger, M.D., Chicago
Robert R. Hartman, M.D., Jacksonville, ISMS Liaison, AAMA Advisor
T.R. Harwood, M.D., Chicago
Leslie Schwartz, M.D., Chicago
Bruce Steffens, M.D., Moline

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services, Inc., is an Illinois corporation, formed in March, 1976, the capital stock of which is owned by the Illinois State Medical Society. It currently acts as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Inter-Insurance Exchange was organized as an insurance reciprocal to provide comprehensive professional liability insurance for Illinois physicians. Membership in the Exchange is limited to members of the Illinois State Medical Society. The Exchange is chartered under the laws of Illinois and functions under the Illinois Insurance Code.

Insurance Services provides management and underwriting services required for operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business. Within these policy guidelines Insurance Services provides management by accepting or rejecting applications, determining the form of insurance policies, and handling and disposing of claims. Insurance Services is compensated by the Exchange on the basis of expense reimbursement.

As a wholly-owned subsidiary, ISMIS provides certain services through ISMS on a shared basis. These shared services are on a direct cost reimbursement basis. Insurance Services includes the Divisions of Underwriting and Claims. In addition, shared services support is provided by ISMS through the Divisions of Administration, Communications, Educational and Medical Services, Governmental Affairs, Computer Services, Human Resources, Finance and Accounting.

Offices of Illinois State Medical Insurance Services, Inc., are at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602; (312/782-2749).

Board of Directors

Warren D. Tuttle, M.D., Harrisburg, *Chairman*
Phillip D. Boren, M.D., Carmi
Alfred J. Clementi, M.D., Arlington Heights
Ulrich F. Danckers, M.D., River Forest
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J.M. Ingalls, M.D., Paris

Officers

Lawrence W. Deidrick, *President*
Alexander R. Lerner, *Secretary-Treasurer*
Henry Nussbaum, *Vice President*, Underwriting
Thomas J. Sullivan, *Vice President*, Claims

ISMS Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, support medical legislation, and assist organized medicine. Auxiliary members raise funds for medical student loans, benevolence and for medical research and education through the American Medical Association Education and Research Foundation (AMA-ERF). Through AMA-ERF, we encourage a sense of giving and work for the support of quality medical education.

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMAA and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927, with 25 members present. In 1928, the organization became permanent. Today, we have a membership of over 2,700 and can look with pride on the auxiliary accomplishments.

We have striven to educate the public on cost effective benefits of preventive healthcare through all segments of our comprehensive Shape Up for Life Program. The auxiliary has instituted a large number of successful community health programs (*e.g.*, vial of life, nutrition, physical fitness, stress management, child seat belt safety, immunization, substance abuse awareness, and teen suicide prevention). This year, we are focusing on membership, legislation and programs to help the elderly. We form coalitions with other community groups and network with organizations to gain their expertise and to lend ours.

The auxiliary has been very active with legislation during the past year. We initiated the legislative internship program and have become quite knowledgeable in lobbying techniques. We also provide information on health-related legislation and are part of a legislative alert system. In an effort to have the auxiliary expand activities in the area of support for the physician's family, we have formed a family advocacy program to address family problems unique to the medical profession, including impairment and malpractice.

Being part of a federation allows us to attend national meetings for leadership training and education. We encourage our county presidents-elect to take advantage of attending AMA Auxiliary Confluence in September and February. All members receive FACETS, a quarterly magazine to keep us abreast of other state activities and to keep us informed.

We communicate throughout Illinois with PULSE, which includes a message from the president.

Officers

President
Mrs. Alex Spadoni, Willow Brook
President-Elect
Mrs. Wayne Kassel, Joilet
1st Vice President
(Membership Coordinator)
Mrs. Wesley Betsill, Springfield
2nd Vice-President
(Program & Project Bank Coordinator)
Mrs. Raymond Hoffmann, Rockford
3rd Vice-President
(Health Projects Coordinator)
Mrs. Richard Newman, Quincy
Secretary
Mrs. Alan Taylor, Danville
Treasurer
Mrs. Norman Taylor, East Alton

Directors

Mrs. Thomas Meirink, Belleville
Mrs. Walter Stevenson, III, Quincy
Mrs. J.D. Winterhalter, Jacksonville

Parliamentarian

Mrs. Harlan Failor, Champaign

District Councilors

1. Mrs. Vernon Guynn, St. Charles
2. Mrs. James Geist, Kankakee
3. Mrs. Silvio DelChicca, Chicago
4. Mrs. Harold Perlmutter, East Moline
5. Mrs. W.G. Thielemann, Carlock
6. *Not Yet Known*
7. Mrs. G. Richard Locke, Decatur
8. Mrs. Grover Seitzinger, Danville
9. Mrs. James Chow, Mt. Vernon
10. Mrs. Robert Chapman, Belleville
11. *Not Yet Known*
12. Mrs. Gareth Eberle, Roscoe

Committee Chairmen

AMA-ERF
Mrs. Alfred Kiessel, Decatur
Archives
Mrs. Harlan Failor, Champaign
Benevolence
Mrs. Louis Tarsinos, Princeton
Boutique Coordinator
Mrs. Selig Hodes, Forreston
Bylaws
Mrs. Robert Reardon, Bloomington
Convention Co-Chairmen
Mrs. Keith Bowser, Shorewood
Mrs. Dwight Woiteshek, Shorewood
Directory
Mrs. Thomas Meirink, Belleville
Editor
Mrs. Allan Minster, Lake Forest
Fall Conference
Mrs. Luis Cespedes, Oak Brook
Finance
Mrs. Robert Webb, Edwardsville
Health Projects Coordinator
Mrs. Richard Newman, Quincy
—Aging
Mrs. Stanley Burris, Springfield
—Child Abuse
Mrs. John McLean, Peoria
—Drugs & Alcohol
Mrs. Walter Stevenson, III, Quincy
—Family Advocacy
Mrs. J.D. Winterhalter, Jacksonville
—Teen Suicide
Mrs. Richard Newman, Quincy
Humanitarian Award
Mrs. Raymond Hoffmann, Rockford
Legislation
Mrs. Alan Taylor, Danville
Membership Coordinator
Mrs. Wesley Betsill, Springfield
Members-At-Large
Mrs. Ronald Severino, Wheaton
Program & Project Bank
Mrs. Raymond Hoffmann, Rockford
Public Relations
Mrs. J. Anthony Dustman, Bloomington
Widows & Spouses of Retired Physicians
Mrs. Earl Klaren, Libertyville

Consultants

Cults
Mrs. George Olander, Lake Forest
International Health
Mrs. Sadiq Mohyuddin, Godfrey
Scrapbook
Mrs. August Martinucci, Joliet
Organ Donation
Mrs. James Monahan, Waukegan
Travel
Mrs. Gamil Arida, Joliet

Representatives to ISMS Councils & Committees

Economics
Mrs. Raymond Hoffmann, Rockford
Education & Manpower
Mrs. Alfred Kiessel, Decatur
Finance & Medical
Benevolence
Mrs. Louis Tarsinos, Princeton
Financial Aid to
Medical Students
Mrs. J.D. Winterhalter, Jacksonville
Governmental Affairs
Mrs. Alan Taylor, Danville
Medical-Legal
Mrs. Robert Reardon, Bloomington
Medical Services
Mrs. Wayne Kassel, Joliet
Mental Health &
Addiction
Mrs. Alex Spadoni, Willow Brook
Public Affairs
Mrs. Alex Spadoni, Willow Brook
Public Relations &
Membership Services
Mrs. Wesley Betsill, Springfield
Sports Medicine
Mrs. Thomas Meirink, Belleville

ISMS Hospital Medical Staff Section

Raymond A. Dieter, Jr., Glen Ellyn, *Chairman*
Joseph L. Murphy, Chicago, *Vice-Chairman*
Thomas C. Malvar, Chicago, *Secretary*
Allan L. Goslin, Streator, *Treasurer*
Silvana Y. Menendez, Belleville, *Delegate*
Dennis M. Brown, Schaumburg, *Alternate Delegate*
Warren D. Tuttle, Harrisburg, *At-Large Member*
Lawrence A. Stone, Des Plaines, *At-Large Member*
Albino T. Bismonte, Gurnee, *At-Large Member*
Jaroslav F. Neskodny, Berwyn, *At-Large Member*

Responsibilities and Purposes

The Hospital Medical Staff Section shall provide representation of hospital medical staffs within the ISMS. The Section will also support the purposes of the ISMS, as stated in its Constitution. Membership in the Section consists of ISMS members who have been elected to represent their individual hospital medical staffs.

ISMS Medical Student Section

Jack Whitney, *Chairman*
Blaine Markee, *Vice Chairman*
Donna Weber, *Secretary*
Lynn Malanfant, *Delegate*
Jodie Rai, *Alternate Delegate*
N. Mark Bates, *MECO Co-Coordinator*
Laura Falls, *MECO Co-Coordinator*

School Representatives

Chicago College of Osteopathic Medicine
Mark Dobbertien, Delegate
Richard Vatt, Alternate
Chicago Medical School
Kenneth H. Herrmann, Delegate
Arthur Taylor, Alternate

Loyola University
N. Mark Bates, Delegate
Eric Dybal, Alternate
Northwestern University Medical School
Gregory Lucchesi, Delegate
Hal Meltzer, Alternate
Rush Medical College
Dipali Apte, Delegate
Diane Mueller, Alternate
SIU School of Medicine
Scott Green, Delegate
Alison Kirby, Alternate
University of Chicago
Barry Ticho, Delegate
Mohamed Khan, Alternate
University of Illinois-Chicago
Howard Chodash, Delegate
Tracy Sanson, Alternate
University of Illinois-Rockford
Guillermo Martinez-Torres, Delegate
Steve Demick, Alternate
University of Illinois-Peoria
Martin Mizener, Delegate
University of Illinois-Champaign/Urbana
Scott Bernstein, Delegate
Mary Nielsen, Alternate

Council Representatives

Rajesh Sinha, Economics
Dipali Apte, Education & Manpower
Mark Dobbertien, Governmental Affairs
Steve Rubin, Medical-Legal
Barry Ticho, Medical Services
Karen Levin, Mental Health & Addiction
William E. Maloney, Public Relations and Membership Services

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee will begin its 27th year as a leader in medical politics in 1987. IMPAC is a voluntary non-profit, unincorporated, permanent membership organization. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his/her spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U.S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U.S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

ISMS Resident Physicians Section

Rockford G. Yapp, III, *Chairman*
Richard Quinones, *Vice Chairman*
Terrence Barrett, *Secretary/Editor*
Janis Orlowski, *Delegate*
Tim Kuzel, *Alternate Delegate*

Council Representatives

Bruce Doblin, Economics
Mike Silver, Education and Manpower
Alan Zunamon, Governmental Affairs
Debra Klamen, Committee on the Impaired Physician
Jonathan Kahn, Medical-Legal
Marilyn Feder, Medical Services
Victor Fernandez, Public Relations and Membership Services

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago College of Osteopathic Medicine
5200 S. Ellis Ave., Chicago, 60615
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
Rush Medical College
1725 W. Harrison St., Chicago, 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. Box 3926, Springfield, 62708
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago, 60637
University of the Health Sciences/The Chicago Medical School
3333 Green Bay Road, North Chicago, 60064
University of Illinois College of Medicine*
Chicago Campus
1853 W. Polk Street, Chicago, 60612

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

ALLIED HEALTH EDUCATION PROGRAMS

Accredited by the American Medical Association Committee on Allied Health Education and Accreditation

Cytotechnologist

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago Lying-in-Hospital

Electroencephalographic Technologist

SPRINGFIELD—St. John's Hospital

Emergency Medical Tech-Paramedic

JOLIET—Silver Cross Hospital

Histologic Technician

CHICAGO—Holy Cross Hospital

PEORIA—St. Francis Hospital and Medical Center
Methodist Medical Center of Illinois

SPRINGFIELD—Memorial Medical Center
St. John's Hospital

Medical Assistants

BELLEVILLE—Belleville Area College

CARTHAGE—Robert Morris College

PALATINE—William Rainey Harper College

RIVER GROVE—Triton College

Medical Laboratory Technician

BELLEVILLE—Belleville Area College

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

GODFREY—Lewis & Clark Community College

GRAYSLAKE—College of Lake County

KANKAKEE—Kankakee Community College

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

Medical Record Administrators

CHICAGO—Chicago State University
University of Illinois at Chicago

NORMAL—Illinois State University

Medical Record Technician

BELLEVILLE—Belleville Area College

CHICAGO—Truman College

DES PLAINES—Oakton Community College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

PALOS HILLS—Moraine Valley Community College

Medical Technologist

BELLEVILLE—St. Elizabeth Hospital

BLUE ISLAND—St. Francis Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Holy Cross Hospital
Louis A. Weiss Memorial Hospital
Michael Reese Hospital & Medical Center
Rush-Presbyterian-St. Luke's Medical Center
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois at Chicago Hospital

DANVILLE—Lakeview Medical Center

DECATUR—Decatur Memorial Hospital
St. Mary's Hospital

EVANSTON—Evanston Hospital

FREEPORT—Freeport Memorial Hospital

HINES—Edward Hines Jr. V.A. Hospital

HINSDALE—Hinsdale Sanitarium & Hospital

JOLIET—St. Joseph Hospital

MAYWOOD—Foster G. McGaw Hosp./Loyola University

NORTH CHICAGO—University of Health Sciences/Chicago Medical School

OAK LAWN—Christ Hospital

OAK PARK—West Suburban Hospital Association

UNIVERSITY PARK—Governors State University

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital and Medical Center

QUINCY—St. Mary's Hospital

ROCK ISLAND—Augustana College/ Quad City Hospital

ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
SwedishAmerican Hospital

SPRINGFIELD—St. John's Hospital
Sangamon State University

Nuclear Medicine Technologist

GLEN ELLYN—College of DuPage

HINES—Edward Hines Jr. VA Hospital

PEORIA—St. Francis Hospital-Medical Center

RIVER GROVE—Triton College

Occupational Therapist

CHICAGO—Chicago State University
University of Illinois at Chicago Hospital
Rush-Presbyterian-St. Luke's Medical Center

Perfusionist

CHICAGO—Mt. Sinai Hospital Medical Center

Radiation Therapy Technologist

CHICAGO—Chicago State University
Michael Reese Hospital/City Wide College

ELGIN—St. Joseph Hospital

EVANSTON—National College of Education

HINES—Edward Hines Jr. VA Hospital

ROCKFORD—SwedishAmerican Hospital

Radiographer

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CARBONDALE—Southern Illinois University

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

CHICAGO—Cook County Hospital
DePaul University
Malcolm X College
South Chicago Community Hospital
University of Illinois at Chicago Hospital
Wilbur Wright College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Memorial Hospital

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Hospital

KANKAKEE—Kankakee Community College

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Black Hawk College/Lutheran Hospital
Moline Public Hospital

NORMAL—Brokaw Hospital

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Hospital Med. Center

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCK ISLAND—Franciscan Medical Center

ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital

SOUTH HOLLAND—Thornton Community College

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

Respiratory Therapist

CARBONDALE—Southern Illinois University

CHAMPAIGN—Parkland College

CHICAGO—Malcolm X College
Northwestern University
University of Chicago Lying-in Hospital

MOLINE—Black Hawk College/Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—Rock Valley College

SPRINGFIELD—Lincoln Land Community College

Respiratory Therapy Technician

BELLEVILLE—Belleville Area Jr. College

CHICAGO—Marion Adult Ed. Career Training Ctr., Inc.
South Chicago Community Hospital

GLEN ELLYN—College of Dupage

KANKAKEE—Kankakee Community College

MOLINE—Black Hawk College/Lutheran Hospital

ROCKFORD—Rock Valley College

SPRINGFIELD—St. John's Hospital

WAUKEGAN—Victory Memorial Hospital

Specialist in Blood Bank Technology

CHICAGO—Michael Reese Hospital and Medical Center
Mid-Amer RC Blood Srvs/C.
Hymen Blood Center
University of Illinois at Chicago Hospital

PARK RIDGE—Lutheran General Hospital

Surgical Technologist

CHAMPAIGN—Parkland College

EAST PEORIA—Illinois Central College

MOLINE—Moline Public Hospital

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

ROCKFORD—SwedishAmerican Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. Each Senate district contains two House districts. Members of the House of Representatives are elected from these 118 single member House districts.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Branch shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS 1986

Governor, James R. Thompson, Rep., Chicago
Lieutenant Governor, George H. Ryan, Rep., Kankakee
Secretary of State, Jim Edgar, Rep., Charleston
Comptroller, Roland W. Burris, Dem., Chicago
Treasurer, James H. Donnewald, Dem., Breese
Attorney General, Neil F. Hartigan, Dem., Chicago

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading, when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading, after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each house can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

Department of Alcoholism and Substance Abuse

State of Illinois Center, 100 West Randolph Street, Suite 5-600, Chicago, 60601.
320 W. Washington St., Suite 505, Springfield, 62701.
William T. Atkins, Director

The Illinois Department of Alcoholism and Substance Abuse is the state agency responsible for the public administration and funding of alcoholism and other drug abuse education, treatment, rehabilitation and prevention programs. The Department is responsible for administration of the Illinois triplicate prescription program for designated product controlled substances, scheduling of controlled substances, licensure for drug abuse programs and controlled substances research, training, and administration of initiatives for special populations and a wide variety of demonstration projects. The Department maintains administrative offices in Springfield and Chicago, and regional offices in Springfield, Chicago, Rockford and Mt. Vernon.

Administrative Staff

Daniel W. Behnke, Deputy Director
Ronald Nelson, Chief Counsel
Davin Robinson, Special Assistant to the Director
Linda Hargnett, Executive Director, Addictions Research Institute
James Bixler, Administrator, Div. of Technology Transfer
Administrator, Division of Prevention & Education
Felix Matlock, Administrator, Div. of Management & Budget
Robert Stachura, Administrator, Division of Support Services
John Woodruff, Administrator, Division of Information Services
Steve Knox, Administrator, Division of Field Services

STATUTORY BODIES

Illinois Interagency Alcoholism and Substance Abuse Board

Lt. Gov. George H. Ryan, *Chairman*
Janet Otwell, Director, Illinois Department on Aging
Ted Sanders, Superintendent, Illinois State Board of Education
Michael P. Lane, Director, Illinois Department of Corrections
James B. Zagel, Director, Illinois Department of Law Enforcement
Ann Kiley, Director, Illinois Department of Mental Health and Developmental Disabilities
Bernard Turnock, M.D., Director, Illinois Department of Public Health
Susan S. Suter, Director, Illinois Department of Rehabilitation Services
Hon. Jim Edgar, Illinois Secretary of State
Gregory Baise, Secretary, Illinois Department of Transportation
Gregory L. Coler, Director, Illinois Department of Public Aid
Gordon Johnson, Director, Illinois Department of Children and Family Services
Gary L. Clayton, Director, Illinois Department of Registration and Education

Illinois Advisory Council on Alcoholism and Substance Abuse

Honorable L. Michael Getty, *Chairman*
Circuit Court of Cook County
Judy H. Fried, *Vice Chairperson*
Northern Illinois Council on Alcoholism
Russell J. Hagen, Vice Chairman
McLean County Alcohol and Drug Assistance Unit
Ronald C. Dozier
McLean County State's Attorney
Donald Paull, Ph.D.
Mental Health Law Division
Robert Holder
Representative of Building Trades
Joseph H. Skom, M.D.
Northwestern University Medical School
Hon. John Matijevich
Illinois State Representative
Hon. George E. Sangmeister
Illinois State Senate
Hon. Jill Zwick
Illinois State Representative
Hon. Frank Watson
Illinois State Senate
Kenneth Robbins
Illinois State Hospital Association
Robert C. Hamilton, M.D.
Illinois State Medical Society
Michael Stroden
Assoc. of Labor-Management Administrators & Consultants on Alcoholism
Antonio Garcia
Hispano Alcoholism Services
David Bingaman
Northwestern House
Rev. Donald M. Hallberg
Lutheran Social Services
Hon. Warren D. Wolfson
Circuit Court of Cook County
Sheriff Richard Doria
DuPage County Court House
Sister Patricia Kilbane
Central States Institute of Addiction
Hon. Terry Steczo
Illinois State Representative
Hon. Dawn Clark Netsch
Illinois State Senator
Hon. Loleta Didrickson
Illinois State Representative
Hon. Forest D. Etheredge
Illinois State Senator
Marian Fiske, Designee
Illinois Nurses Association
Dean Sweet
Sangamon-Menard Alcoholism and Drugs Council
Jack Arkins
Illinois Pharmacists Association
Eldoris Mason
Brass Foundation, Inc.
Larry Wilms
Prairie Center
Peter Bokos, Ph.D.
Interventions, Inc.

Department of Children and Family Services

100 W. Randolph, Sixth Floor, Chicago, 60601
406 East Monroe, Springfield, 62701
Gordon Johnson, Director

The Illinois Department of Children and Family Services is the state agency responsible for providing child welfare and child protection services to children and their families. The current caseload is 39,500 children and families. Services provided by the Department, either directly or through purchase from private agencies, include counseling; the care of children in foster homes, group homes, and institutions; adoption; day care; help to unwed parents, and the licensing and monitoring of some 16,000 child

care facilities. The Department also contracts with individuals as advocates and homemakers to work with children and parents on a one-to-one basis.

The Department has three main divisions responsible for delivering services. The Division of Child Protection is responsible for investigating reports of suspected child abuse and neglect. In fiscal year 1986, more than 70,000 children were reported as suspected abuse or neglect victims.

The Division of Youth and Community Services specializes in services for adolescents. It is responsible for a grant-in-aid program of community-based services to troubled youth, juvenile justice and delinquency prevention programs, a multi-agency program for emotionally disturbed youngsters, and a variety of youth employment programs. Through the Department's eight service regions, the Division of Program Operations administers the agency's various service programs for abused, neglected, and dependent children and their families.

Director's Office

Paul Freedlund, Executive Deputy Director
Michael Horstman, Special Assistant to the Director
Janis Forte, Special Assistant to the Director
Thomas E. Villiger, Deputy Director, Division of Child Protection
William Hall, Deputy Director, Division of Policy and Plans
Constance Mercer, Deputy Director, Division of Program Operations
Bruce Rubenstein, Deputy Director, Division of Youth and Community Services
David Richards, Deputy Director, Division of Management and Budget
Jo Warfield, Chief, Office of Communication/Community Relations
Mauriece Graham, Chief, Office of Audits
William Curtis, Chief Counsel, Office of Legal Services
Chuck Murphy, Chief, Office of Employee Services
William Rodman, Legislative Liaison
Robert T. Blackwell, Chief, Office of Program Review
Linda Avery, Chief, Office of Inter-Agency Coordination

Regional Offices

Thomas Brinton, Region 1A Administrator, Rockford
Thomas Ward, Region 1B Administrator, Peoria
Jack Zentz, Region 2A Administrator, Aurora
Roland Kulla, Region 2B Administrator, Chicago
William Gillespie, Region 3A Administrator, Springfield
Willis Hartman, Region 3B Administrator, Champaign
Anthony Jenkins, Region 4 Administrator, East St. Louis
Gene Ruehmkorff, Region 5 Administrator, Marion

Advisory Councils

DCFS Advisory Council, Karyl Thorsen, Chairperson
Statewide Citizen's Committee on Child Abuse and Neglect, Joseph P. Mayo, Chairperson
State Advisory Committee on Day Care, Laurel Walker, Chairperson
Illinois Juvenile Justice Commission, Dallas C. Ingemunson, Chairperson
Statewide Foster Care Advisory Committee, Emil Stahlhut, Chairperson

In addition to the above, each of the eight regions has its own advisory committee and various youth planning committees.

Department of Corrections

100 West Randolph, 4th Floor, Chicago, 60601
1301 Concordia Ct., P.O. Box 19277, Springfield, 62794-9277
Michael P. Lane, Director

Leo L. Meyer, Deputy Director-Adult Division
James R. Irving, Deputy Director-Juvenile Division
Douglas A. Brown, Deputy Director-Community Services Division
J. Thomas Hutchison, Deputy Director-Bureau of Administration and Planning
William H. Craine, Ph.D., Deputy Director-Bureau of Employee and Inmate Services
Gerald O. Long, Deputy Director-Bureau of Inspections and Audits
Samuel J. Sublett, Accreditation Manager
Nic Howell, Chief Public Information Officer
Melissa A. Stutler, Chief of Intergovernmental Relations
Dr. Ronald Shansky, Medical Director

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the security, physical and mental needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, adjustment and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the state.

Department of Mental Health and Developmental Disabilities

401 S. Spring St., Springfield, 62706
State of Illinois Center, 100 West Randolph, Suite 6-400, Chicago, 60601
Ann M. Kiley, Director

Colette Croze, Deputy Director for Field Services
John Fangman, Deputy Director for Central Operations
Ivan Pavkovic, M.D., Associate Director for Clinical Services
Ugo Formigoni, M.D., Associate Director for Mental Illness
William Murphy, Associate Director for Developmental Disabilities
Terry Brelje, Ph. D., Associate Director for Policy & Special Programs
Virginia Conlee, Executive Assistant to the Director
Doug Carey, Executive Assistant to the Director
Russell Blaauw, Legislative Liaison
D. Jean Ortega-Piron, Chief Counsel

David Thomas, Chief Auditor
Lynn Shehorn, Administrative Assistant
Harriett Mitchell, Administrative Assistant

STATUTORY BOARDS AND COUNCILS

Psychiatric Advisory Council

Harold M. Visotsky, M.D., Chicago
Ann M. Kiley, Director, Springfield
Wayne R. Anable, D.O., Chicago
James T. Barter, M.D., Chicago
Robert E. Becker, M.D., Springfield
Robert deVito, M.D., Maywood
Jan Fawcett, M.D., Chicago
Ugo Formigoni, M.D., Springfield
Daniel Offer, M.D., Chicago
George H. Pollock, M.D., Chicago
Lester H. Rudy, M.D., Chicago
Charles Schuster, Ph.D., Chicago
Ivan Pavkovic, M.D., Chicago
Patrick R. Staunton, M.D., Park Ridge
Michael Taylor, M.D., North Chicago

Medical Review Board

Grant C. Johnson, M.D., Springfield, Chair
John Crayton, M.D., Chicago
Anthony D'Agostino, M.D., Chicago
Phillip Epstein, M.D., Chicago
Saul Haskell, M.D., Chicago
Zena Lillian, M.D., Chicago
Sergio Rabinovich, M.D., Springfield
Marshall Short, M.D., Chicago
Raymond Teplitz, M.D., Berwyn
Philip Woollcott, M.D., Evanston

Department of Public Aid

100 South Grand Ave. East, Springfield, 62762
624 S. Michigan Ave., Chicago, 60605
Gregory L. Coler, Director

The Illinois Department of Public Aid assists over one million Illinois residents experiencing financial or medical hardships. The Department administers the following programs: Aid to Families with Dependent Children, Medical Assistance, and Aid to the Aged, Blind, or Disabled. The Department also allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp Program. The Child Support Enforcement Program is a joint effort of the Department, the Attorney General, and local state's attorneys to obtain court-ordered child support from parents. Support enforcement services are provided to any family who needs help collecting child support. The Department's Office for Hospital Services in the Medical Programs Division administers the Illinois Competitive Access and Reimbursement Equity Program (ICARE), which assures access to quality hospital care for recipients and promotes competition among hospitals for the purchase of their services. Among other initiatives within the Medical Programs Division are nursing home reform and prepaid health programs.

Administrative Staff

Michael Taylor, Executive Deputy Director
James Stumpf, Office of Legislation
Janice Boone, Special Assistant to the Director
Randale Valenti, Associate Director, Office of Employment and Social Services
Johnetta W. Jordan, Chief, Office of Public Information
David Peterson, General Counsel, Office of Counseling and Litigation
Mary Ann Langston, Policy & Planning Administrator
Fred Sapetti, Acting Medical Programs Administrator
Norman Ryan, General Services Administrator
Gail Huecker, Operations Administrator
Gerald Slavens, Chief, Financial Recovery

Hospital Service Procurement Advisory Board

Irving Harris, Chicago, *Chairman*
John J. Wolfe, Hazel Crest
Audley F. Connor, Jr., M.D., Chicago
Alfred J. Clementi, M.D., Arlington Heights
Jerry Hickham, Carbondale

Medical Advisory Committee

F. Daniel Cantrell, Chicago
Gloria Casey, Springfield
Bertha Dorsey, Chicago
Barbara Dunn, Decatur
Sam Enloe, R.Ph., Decatur
Laura Landrum, Springfield
Joseph L. Gannon, Lombard
Gary G. Hauser, O.D., Chicago
Peter Kuhn, D.D.S., Chicago
Sheila Mahtesian, Chicago
Phillip M. Moore, Chicago
Pete Peters, Chicago
Edwina Quinn, Chicago
Ruth Rothstein, Chicago
Patricia R. Terrell, Chicago
Susan Weed, Chicago
Fred Z. White, M.D., Chillicothe
Betty Williams, Chicago
Virginia Williams, R.N., McHenry
Rev. Richard Wood, Springfield

State Medical Advisory Committee

Audley F. Connor, Jr., M.D., Chicago
Roger DeCook, M.D., Downers Grove
Charles Frazer, M.D., E. St. Louis
Thomas John, M.D., Chicago
Eugene P. Johnson, M.D., Casey
Gayle L. Kates, M.D., Chicago
Terry Mason, M.D., Chicago
George T. Mitchell, M.D., Marshall
Robert C. Muehrcke, M.D., Oak Brook
Paul Norris, M.D., Peoria
Ann Pearson, M.D., Springfield
Dennis A. Reter, D.O., Canton
Arthur R. Traugott, M.D., Urbana
Fred Z. White, M.D., Chillicothe

Department of Public Health

535 West Jefferson St., Springfield, 62761
Bernard J. Turnock, M.D., Director

The Illinois Department of Public Health promotes the good health of the public through the administration of more than 100 programs and services aimed at preventing illness, eliminating health hazards, regulating health-care facilities, identifying and controlling outbreaks of disease and reducing health-risk factors.

The scope and variety of programs administered by the Department encompass all aspects of preventing disease and disability, thus improving the quality of life for Illinois residents.

The reduction of infant mortality; nutrition services; pre- and postnatal care; dental health; emergency medical services; childhood immunizations; maintenance of breath-analysis equipment; control of sexually transmitted diseases; assuring the purity of food, milk and drugs; regulation of health-care facilities; elimination of health hazards from

the environment; licensure and regulation of swimming pools and other recreational areas; support to local health departments; consumer product safety; and the registration of births, deaths and other vital statistics are among the myriad of programs and services administered by the State Health Department.

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Walter DeWeese, Internal Auditor
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Tim O'Brien, Chief Counsel
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The authority for the Medical Determination Board was deleted by S.B. 864 (PA 84-1085). The Medical Determinations Board was recreated by H.B. 1947 (PA 84-1064).

Membership of the recreated Medical Determinations Board is currently pending.

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POISON CONTROL CENTERS IN ILLINOIS

For information contact:
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Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 785-2080

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS
Illinois Department of Public Health
Division of Disease Control

For information contact:
Mary Mahoney—Coordinator, Direct Services Programs
Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield, 62761
Phone (217) 782-3303

Department of Registration and Education

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The Department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Practice Examining Committee, appointed by the director of the Department, operates within the framework of the Act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

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MEDICAL PRACTICE ACT

Due to its lengthy nature, *IMJ* is unable to publish the complete text of the Medical Practice Act. However, because of its importance to the practicing physician, members are encouraged to obtain a copy of the Act from the Department of Registration and Education, 320 W. Washington Street, Springfield, 62786.

The Illinois Medical Practice Act will come under close scrutiny this year, as the General Assembly considers its provisions under the "sunset" rule. As related in the September *IMJ* (170:3, 143, 1986), the law governing licensure and discipline of Illinois physicians will expire December 31, 1987.

When a law of this scope is up for evaluation, any number of amendments can be suggested and passed. Amendments proposed in recent sessions of the General Assembly would have increased the medical license fee, required mandatory retesting for licensure and mandated automatic license revocation for a specified number of malpractice suits. Additionally, it's likely that allied health professionals will seek to expand their scope of licensure or limit the physician's authority as the Act undergoes "sunset" review.

Illinois physicians will be advised of proposed changes to the Act through *On the Legislative Scene* and other ISMS publications. Individual physicians are urged to stay current on these issues, as the structure of the Act defines the climate of medical practice in Illinois.

Department of Rehabilitation Services

623 East Adams Street
Springfield, 62706
Susan S. Suter, Director

The Department of Rehabilitation Services (DORS) is the state's leading agency helping children and adults with disabilities to reach their full potential and their goals for a productive independent life. Funded by state and federal funds, DORS provides a variety of rehabilitation services to eligible persons, including children who cannot be adequately served by their local public schools; adults of or near working age who have diagnosable physical and/or mental disabilities which interfere with their ability to get or keep jobs; and adults with severe disabilities under age 60 who are at risk of institutionalization but who could remain at home if certain, specific services were provided.

DORS assists clients in selecting the needed services; serves as a link to service groups, rehabilitation facilities and other governmental agencies; and makes medical eligibility determinations for persons applying for benefits under the Social Security Disability Insurance and Supplemental Security Income programs.

DORS offers its services through a number of program components, including the Vocational Rehabilitation Program, the Home Services Program, the Illinois Visually Handicapped Institute, Community/Field Services for the Visually Handicapped, the Illinois School for the Deaf, the Illinois Children's School and Rehabilitation Center, the Illinois School for the Visually Impaired, secondary school work experiences and the Vending Stand Program.

Illinois Health Care Cost Containment Council

516 E. Monroe St., Suite 200, Springfield, 62701
James S. Tripp, Executive Director

In August, 1984, Illinois Governor James R. Thompson signed into law Senate Bill 495, which created a new body reporting directly to the Illinois General Assembly independent of any specific code department. That body, the Illinois Health Care Cost Containment Council, was appointed to fulfill the legislative mandate to hold down the cost of health care in Illinois. It was instructed to establish a data system which will collect bills for all hospital discharges, to prepare quarterly public reports on health care charge and utilization trends and to recommend additional methods to restrain the rise in health care costs. Three health care providers, three consumers, two insurers and three representatives of the business community were appointed.

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The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the reference section. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

Name: _____ **City:** _____ **Zip:** _____

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Telephone:( ) _____

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Medical specialty and type of practice: _____

Committee in which interested: _____

Expertise for this committee: _____

Send to: Chairman, Board of Trustees, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

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Auxiliary Membership

By Sherry S. Betsill/Springfield

All of my life I have heard that medicine is changing. Forty years ago, my father and his colleagues had only a small inkling of what was to come. Medicine has changed from the days when my grandfather made house calls in a horse and buggy to my father's urban hospital practice to my husband's large multispecialty clinic practice. But it is still people caring for those in need.

Medical auxiliary has also evolved over the years. It is no longer just a social group and an organization of women. There are now male auxiliaries—not many, granted, but their numbers are growing and their membership should be encouraged.

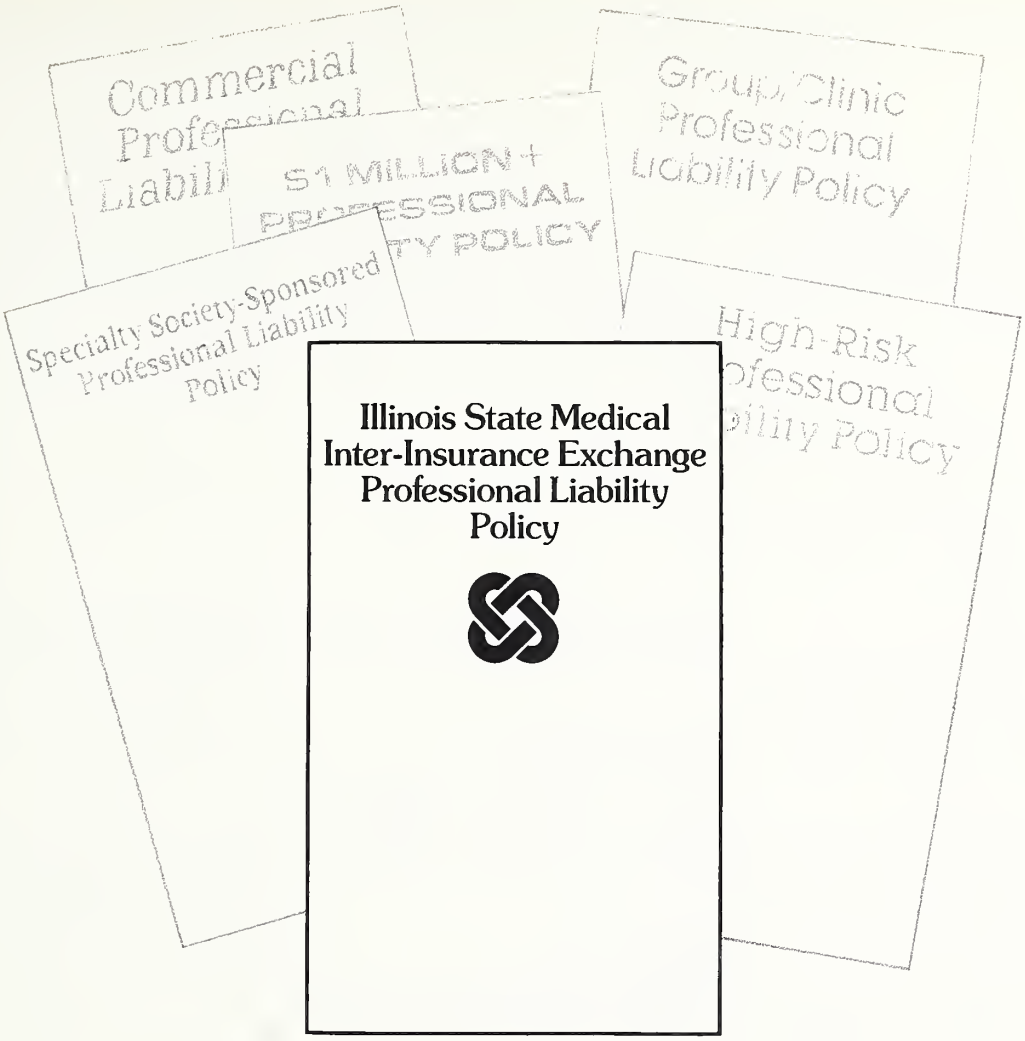
In this day and age, when everyone seems to be striving for his or her own identity, would anyone want to join a group whose purpose is to support a spouse's occupation? I think the answer must be "yes."

Since its inception in 1928, the Illinois State Medical Society Auxiliary has been dedicated to improving the quality of health care for the citizens of Illinois. The county auxiliaries work closely with their local medical societies to fill community needs through education, service projects and legislative activity.

As more and more demands are placed on physicians they have less time to devote to community service. The Auxiliary plays an important role as liaison between the community and the medical profession. We, as Auxiliary members, must constantly recruit membership. There are many organizations vying for a dwindling number of volunteers and prospective members do not join an organization unless they are fully acquainted with its programs and goals. We must remember that our members share a mutual bond as physician spouses.

Once the decision to join the auxiliary has been made, there is no assurance that the initial interest will continue unabated. A new member must be made to feel welcome. One of the best ways to accomplish this goal is to get the person immediately involved with an activity. Most of our county auxiliaries have projects. For example, teenage suicide is a continuing focus for many of our counties. Volunteers are trained and programs dealing with suicide prevention are presented throughout the state. Medical legislation, of utmost importance last year, will continue to be a central concern this year. We must encourage our new members, as well as our long-standing members, to be politically active. These are just a few of the areas in which a new member may become involved. We hope that this involvement will develop a long-term commitment.

Oliver Wendell Holmes once said, "The great thing in this world is not so much where we stand, as in what direction we are going." If we seek new knowledge and information we will truly be able to become multi-dimensional, and there is no limit to what we might accomplish. This is certainly true of medical auxiliary. We can expand our knowledge by taking advantage of the many excellent mini-seminars offered by the AMAA and the ISMSA and, by working together as a group, we can continue to make an impact on our communities. ◀



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The number and size of damage claims against physicians continues to rise. And it's drying up most sources of malpractice insurance for Illinois doctors.

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Twenty North Michigan Avenue
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Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (Toll-Free)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

NOVEMBER

Allergy

Clinical Allergy For the Practicing Physician
For: Physicians. Seminar, November 6-8, St. Louis. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $175. **Reg. Limit:** 150. **Credit:** Category 1: 19.25 hours; AAFP Prescribed: 19 hours; AOA: 19.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Anesthesia

Workshop in Fiberoptic Endoscopy
For: Anesthesiologists. Lecture, November 8, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $225. **Reg. Limit:** 50. **Credit:** Category 1: 7 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiac Rehabilitation

For: Physicians and other health professionals. November 10-14, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, Mitchell Hall, LaCrosse, WI 54601 and the Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP Prescribed: 35 hours; 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D. **Phone:** (608) 785-8686.

Geriatric Medicine

43rd Annual Scientific Meeting of American Geriatrics Society and 7th Annual Meeting of American Federation for Aging Research
For: Physicians. Convention, November 16-19, Chicago, IL. **Sponsors:** American Geriatric Society, 10 Columbus Circle, Rm. 1470, New York, NY 10019; American Federation for Aging Research. **Fee:** $125 (members), $150 (non-members). **Reg. Limit:** None. **Credit:** Category 1: 27 hours; AAFP Prescribed: 27 hours. **Contact:** Barbara Popecki. **Phone:** (212) 582-1333.

Aging and Illness in Primary Care: The 5th Symposium on Clinical Problems and the Future of Health Care of the Elderly
For: Physicians and other health professionals. Symposium, November 13-14, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Departments of Medicine and Family Medicine, School of Medicine; and Geriatrics Institute, Mt. Sinai Medical Center. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 15 hours; AAFP Prescribed: credit pending; AOA Category 2-D: pending; and University of Wisconsin CEU's: 15 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Neurosurgery

Neurosurgery Laser Workshop
For: Neurosurgeons. Workshop, November 17-18, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Registration Limit:** 12. **Credit:** Category 1: 19 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Obstetrics/Gynecology

Hysteroscopy Workshop
For: Gynecologists. Conference and workshop, November 14-15, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $325. **Reg. Limit:** 150. **Credit:** Category 1: 11.5 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Obstetrics/Gynecology/Family Medicine/Pediatrics

New Technologies in Clinical Genetics
For: Ob/Gyn's, pediatricians and family practitioners. Lecture, November 15, Holiday Inn-Aisip, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $35. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Elective: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine

Child Abuse
For: Physicians. Conference, November 3-5, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 18 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Antihypertensive Therapy-Changing Focus
For: Physicians. Symposium, November 12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Registration Limit:** 175. **Credit:** Category 1: 5.75 hours; AAFP Prescribed: 5.75 hours; and ADA: 5.75 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Infectious Diseases Seminar
For: Physicians. Seminar, November 19, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Registration Limit:** 300. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; and ADA: 6 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Surgery

Ins & Outs of Critical Care
For: Physicians. Conference, November 11-12, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 12 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Continuous Monitoring by Venous Oximetry
For: Physicians and allied health professionals. Conference, November 14. **Sponsor:** University of Michigan Medical School, Townsley Center, Box 0201, Ann Arbor, MI 49109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6.25 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Michigan Society of Critical Care Medicine
For: Physicians. Conference, November 15, Ann Arbor, MI. **Sponsor:** Michigan Society of Critical Care Medicine, Townsley Center, Box 0201, Ann Arbor, MI 48109. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Amy Niemann. **Phone:** (313) 764-2288.

Medical and Surgical Approaches to Pulmonary and Esophageal Diseases
For: Physicians and other health professionals. Conference, November 7-8, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Department of Surgery, School of Medicine. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; AAFP Elective: credit applied for; AOA Category 2-D and University of Wisconsin CEU's: 9 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Internal Medicine/Family Medicine

Management of Thromboembolism: Update 1986
For: Internists and cardiologists. Symposium, November 1, 8:00 a.m.-5:00 p.m., Chicago. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 8 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

AIDS: Understanding and Managing the Disease

For: Internists, family practitioners, and general practitioners. Symposium, November 7, 8:00 a.m.-5:00 p.m., Evanston Hospital, Evanston, IL. **Sponsors:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Avenue, Chicago, IL 60611; and Evanston Hospital, Department of Medicine. **Fee:** $50. **Reg. Limit:** None. **Credit:** Category 1: 8 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Focus on Rheumatology-1986

For: Physicians and other health professionals. Conference, November 7-8, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705; Department of Medicine, School of Medicine; and University of Wisconsin Hospital and Clinics. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed: 10 hours; AOA Category 2-D and University of Wisconsin CEU's: 10 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Perspective in Diabetes Mellitus 1986

For: Physicians and other health professionals. Conference, November 14-15, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Department of Medicine, School of Medicine. **Fee:** To be announced. **Reg. limit:** None. **Credit:** Category 1: 12 hours; AAFP Prescribed: credit applied for; AOA Category 2-D and University of Wisconsin CEU's: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pediatrics

National Studies of Perinatal Care
For: Pediatricians and family physicians. Seminar, November 15, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

DECEMBER

Obstetrics/Gynecology

Advanced Colposcopy and Laser Surgery
For: Gynecologists. Conference and workshop, December 4-6, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $325. **Reg. Limit:** 110. **Credit:** Category 1: 16 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Problem Solving in Gynecologic Endocrinology and Infertility
For: Obstetricians and gynecologists. Course, December 12-13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolaryngologists. Laser workshop, December 8-9, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Neurology

Neurology for the Non-Neurologist
For: Family practitioners, internists, and psychiatrists. Lectures/workshops, December 10-12, Chicago. **Sponsor:** Rush University, Rush Presbyterian-St. Luke's Med. Center, University Office of CME, 600 S. Paulina, Chicago, IL 60612. **Fee:** To be determined. **Reg. Limit:** none. **Credit:** Category 1: 20 hours; AAFP elective: Credit applied for. **Contact:** Barbara Trejo. **Phone:** (312) 942-7095.

Surgery

Symposium on Vascular Emergencies
For: Surgeons. Symposium, December 11-13, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $450. **Reg. Limit:** 500. **Credit:** Category 1: 16.5 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Family Medicine

Low Back & Sciatic Pain: Evaluation & Treatment
For: Physicians. Seminar, December 12-13, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. Limit:** 150. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; and AOA: 12 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Cardiology

Cardiovascular Practice 1986-87: A Summary for the Current Physician
For: Physicians and other health professionals. Conference, December 5, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Cardiology Section, Department of Medicine, School of Medicine, University of Wisconsin-Madison. **Fee:** To be announced. **Registration Limit:** None. **Credit:** Category 1: 7 hours; AAFP Prescribed: credit applied for; AOA Category 2-D and University of Wisconsin CEUs: 7 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

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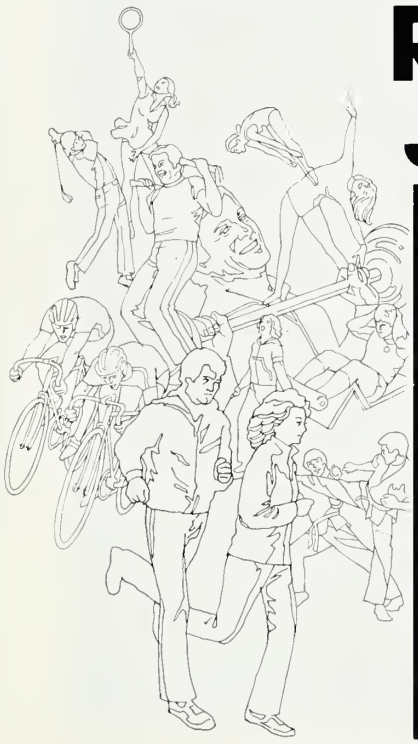
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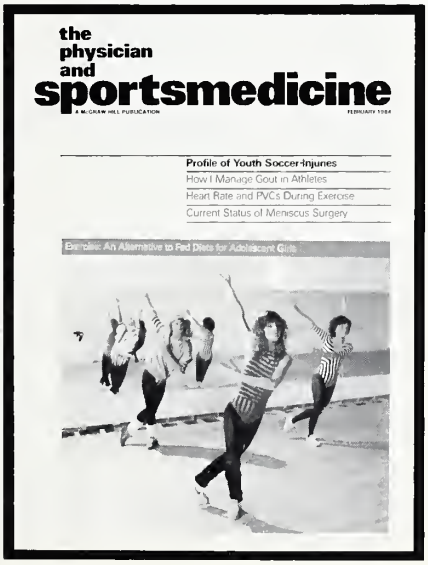
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Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

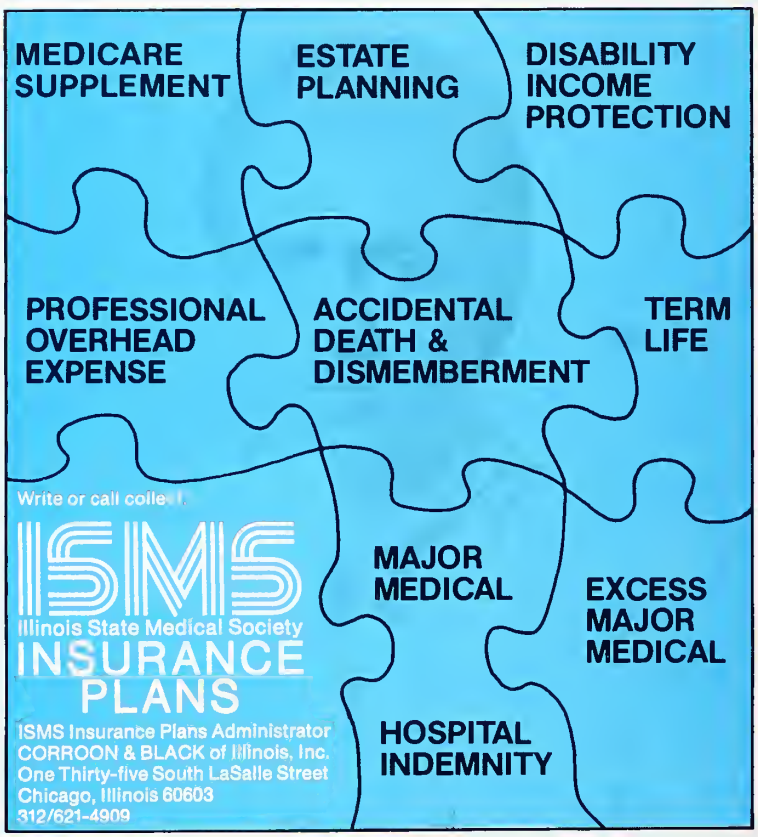
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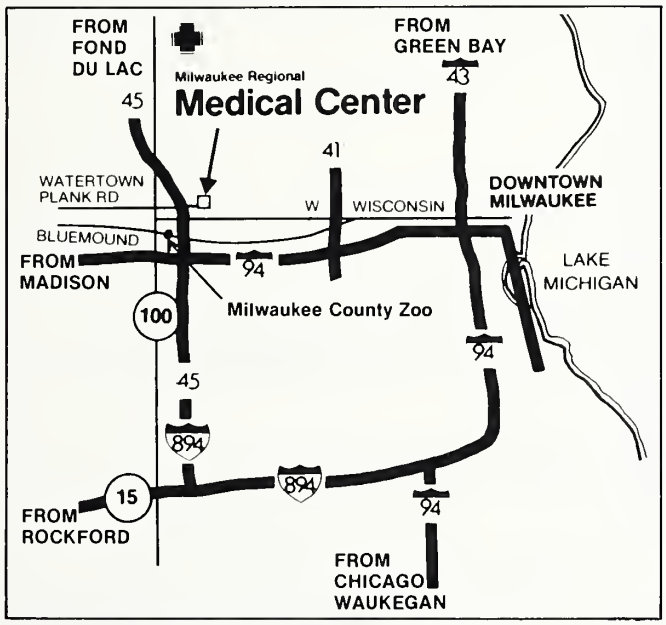
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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies.

FROM THE DEPARTMENT OF REGISTRATION AND EDUCATION (DRE)

Medical Disciplinary Orders

- *John Dale Cavaness* (lic. #036-032087)
  Effective June 27, 1986, Dr. Cavaness' medical license was revoked.
- *John Bartholomew Davis* (lic. #036-036402)
  Effective June 27, 1986, Dr. Davis' medical license was restricted and placed on a 2-year probation.
- *Joshua A. Fierer* (lic. #036-057021)
  Effective July 10, 1986, Dr. Fierer's medical license was suspended.
- *Howard Horton* (lic. #036-042944)
  Effective June 27, 1986, Dr. Horton's medical license was suspended.
- *Karl H. Laping* (lic. #036-064036)
  Effective June 27, 1986, Dr. Laping's medical license was placed on a 3-year probation.
- *Branko Placik* (lic. #036-036295)
  Effective June 27, 1986, Dr. Placik's medical license was revoked, but the revocation was stayed and his license was placed on a 2-year probation.
- *Calvin F. Scott* (lic. #003-036-063248-1)
  Effective June 27, 1986, Dr. Scott's controlled substance license to prescribe Schedule II controlled sustances was suspended, and his license for Schedules III, IV, and V controlled substances was placed on probation.

(Source: Disciplinary orders received from the Director of DRE)

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City of Chicago
Department of Health

Director of Maternal & Child Health Programs

Qualifications

- M.D. degree and license to practice medicine in Illinois.
- Masters Degree in Public Health and special training in Maternal and Child Health.
- Board Certification in Pediatrics, Neonatology and/or Obstetrics and Gynecology.

Experience: Professional and administrative experience in Public Health with knowledge of the methods, techniques, and literature in medical science. Must be able to apply principles of personnel administration to supervision and coordination of professional staff.
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The City of Chicago offers a full range of benefits. All applicants must be residents of the City of Chicago at time of employment.

Qualified applicants for this position should submit resumes to: Richard M. Krieg, Ph.D., Deputy Commissioner of Health, Room 219, Richard J. Daley Center, 50 West Washington, Chicago, Illinois 60602.

The City of Chicago is an Equal Employment Opportunity/Affirmative Action Employer.

$100,000 +

Guarantee, plus other incentives, for approved physicians in the following specialties in Mid-Michigan community —

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POSITIONS AND PRACTICE

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Allison Katz, Staffing Specialist. National Emergency Services, Inc., 255 Executive Drive, Suite 104, Plainview, NY 11803 or call (800) 645-4848 or (516) 349-0100.

ARIZONA BASED Physician recruitment firm has opportunities coast to coast. "Professionals working with Professionals." Over 14 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PRACTICE/Internal Medicine—Central Illinois. Various opportunities available: solo and group. Reply to Box 1186, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WELL ESTABLISHED PRACTICE for sale. General practice and general surgery. Chicago suburb. Will introduce up to one year. Grossing over $200,000. Reply to Box #2006, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SURGEON: Looking for associate in the established practice of general surgery. Suburb of Chicago. May eventually buy in one year. Reply to Box #2007, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

IMMEDIATELY NEEDED: Family practice/internist. Guaranteed $35/ hour plus percentage. Close to St. Louis. Hospital privileges: community and St. Louis. Call (618) 254-7478.

INDUSTRIAL CLINIC needs physician part-time weekdays in southwest suburb. Need Illinois license and your own malpractice. Send resume and hours available to: Southwest Industrial Care, 7600 W 119th St, Palos Heights, IL 60463.

FAMILY PRACTICE—Immediate need for two B/C family practitioners for opportunity in Phoenix, AZ. For more details, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

IMMEDIATE OPENING full-time emergency physician at trauma center southwest of Chicago. Considerable exposure to acute trauma. Partnership within one year, remuneration exceeding six figures. Must be board certified in internal medicine, or at least two/three years experience in emergency medicine. Contact W. L. Gordon, (815) 744-2800.

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE OB/GYN, FP, pediatric physicians coast to coast. For further information, call Mitch Young at (602) 795-7474; or send C.V. to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

FAMILY PRACTITIONER. Board certified or eligible to join 11 physician, expanding multi-specialty practice in northern Wisconsin. Clinic adjoins JCAH hospital. Rural location with abundant outdoor recreational opportunities, small four year college. Excellent salary and benefits. Call collect (715) 532-6651 or send curriculum vitae with names of references to: Marshfield Clinic—Ladysmith Center, Howard T. Chatterton, M.D., 906 College Avenue W., Ladysmith, WI 54848.

HEALTHLINE PHYSICIAN SERVICES, An affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman at Healthline Physician Services, 8401 Hanley Industrial Ct., St. Louis, MO 63144.

IMMEDIATE OPENING. One staff psychiatrist and one general practitioner at 250-bed acute treatment psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Forty-hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $73,445.00. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B. J. Dave, M.D., Superintendent, Mental Health Institute, Independence, IA 50644. Telephone: (319) 334-2583. An equal opportunity employer.

GENERAL PRACTICE PHYSICIAN opportunity in a prosperous and progressive, rural community in central Illinois. Excellent schools make this an ideal location for a practitioner with a young family. Recreation, including a vast Federal lake for fishing and water sports, abounds. Solo practice should gross six figures first year. Office suites available and financial arrangements are open. Contact Garland Strohl, CEO of Shelby Memorial Hospital, Shelbyville, IL 62565. Phone 217/774-3961.

FAMILY PRACTITIONER Board certified or eligible to associate with general surgeon with well established Waukegan practice. Must be fluent in Spanish and English. $50,000 yearly guaranteed with fringe benefits and malpractice. Illinois license required. Reply to Box #2018, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PEDIATRICIAN TO JOIN well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL

60178.

FAMILY PRACTICE SPECIALIST. Marshfield Clinic department of family medicine is seeking a BE/BC family practitioner to replace a retiring colleague. The physician joining this six member department will enjoy the support of one of the nation's largest multispecialty groups, share the philosophy of family oriented care with a preventive focus, and enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Marshfield Clinic offers an excellent salary plus extensive fringe benefits. Please send curriculum vitae to: John Folz, Assistant Director, Marshfield Clinic, Marshfield, WI 54449, or call collect at (715) 387-5181.

UNIVERSITY HEALTH SERVICE: Twelve month position in primary care to young adults with major responsibility for sports medicine program. Illinois license or eligibility therefore. Completion of residency and board certified preferred. Significant sports medicine/trauma experience required. Student population 26,000, accredited health service. Semi-rural community of 30,000 with many cultural advantages, 1½ hours from Chicago. Inquiries with C.V. to: Rosemary B. Lane, M.D., Director, NIU Health Service, DeKalb, IL 60115-2879. (815) 753-1314 for further information. EOE/AA employer.

PEDIATRICIAN—Excellent opportunity to join four pediatricians in a very active practice. Growing community, excellent hospital with teaching opportunities available. Close to Milwaukee. John R. Guy, M.D., 1111 Delafield Street, Waukesha, WI 53188; (414) 542-2536.

WANTED—E.R. Physicians—STAT,P.C., a professional corporation providing St. Joseph Mercy Hospital emergency department physician services, looking for qualified part-time or full-time physicians to staff the emergency department. Please direct inquiries to Lambert C. Orton, M.D., STAT,P.C., 84 Beaumont Drive, Mason City, IA 50401. (515) 424-STAT(7828).

GREEN BAY, WISCONSIN: 27 physician multi-specialty group seeking BC/BE physicians in the following specialties: family practice, ophthalmology, dermatology, plastic surgery, radiology, OB-GYN, internal medicine and pediatrics. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The clinic offers competitive salary and excellent fringe benefits. Interested physicians please contact: W. J. Mommaerts, Administrator, West Side Clinic, S.C., 1551 Dousman Street, Green Bay, WI 54303.

OB/GYN's—We represent clients in Illinois, Iowa, Michigan, Montana, North Dakota, and Wisconsin. Opportunities with multispecialty groups, partnerships, and solo fee-for-service positions are available. For detailed information, please send your C.V. or call: Jim Huber, Fox Hill Associates, 250 Regency Ct., Waukesha, WI 53186, (414) 785-6500 (collect).

ORTHOPEDIC SURGEON—Join progressive multispecialty group in pleasant, riverfront community west of Chicago. Heavy patient volume. Competitive guarantee plus attractive benefits. For immediate information, call: Dorothea Anich, Fox Hill Associates, 250 Regency Ct., Waukesha, WI 53186, (414) 785-6500.

PLEASANT CENTRAL ILLINOIS college town within easy reach of large metropolis. Modern 130-bed hospital. Recreational facilities abundant. Lucrative practice with future to take over. Reply to Box #2034, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OBSTETRICIAN/GYNECOLOGIST. Progressive five physician OB/GYN department in 60 physician multispecialty group seeks sixth associate. Attractive location in western Chicago suburbs. Very good family opportunities and professional growth. Excellent hospital facilities backed with strong neonatal program. Forward curriculum vitae: Dave S. Bauer, III, Executive Director, or Joseph J. Nigro, M.D., 454 Pennsylvania Avenue, Glen Ellyn, Illinois 60137.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice, pediatrics and OB-GYN. Positions include income guarantee and no capital investment. For more information, contact Barry Trautman, 8401 Hanley Industrial Ct., St. Louis, MO 63144, (314) 962-1233.

CARDIOLOGY: 56-MD multispecialty group seeking second cardiologist to associate in an excellent growing consultative practice, combining both invasive and non-invasive opportunities. Well equipped offices in a modern, accredited facility. Drawing area nearly 400,000 with two well-staffed, modern hospitals. Stimulating Mid-West Big-10 University community of 100,000 with superb cultural advantages. Ideal for family. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship and subsequent income based exclusively on productivity. Send C.V. to Box #2004, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PRIMARY CARE PHYSICIANS needed for hospital supported private practice program sponsored by progressive 400+ bed Chicago northside hospital. Two excellent opportunities are currently available for partnerships with established physicians nearing retirement. One practice is located on the northside and the other in Skokie. Send C.V. to Box #2032, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MINNEAPOLIS—Family practice, internal medicine, cardiology, child psychiatry, adult psychiatry, obstetrics/gynecology, ophthalmology. Join established group in one of America's leading metropolitan areas. Group provides professional liability, four weeks vacation, two weeks conference leave, disability, retirement, hospital dues and more. Must be board certified or board eligible. Direct inquiries to: Paul J. Brat, M.D., Medical Director, Group Health, Inc.; 2829 University Ave. S.E., Minneapolis, MN 55414.

EMERGENCY CONSULTANTS, INC. provides emergency department services to hospitals in Alabama, Illinois, Indiana, Michigan, New York, Ohio, Pennsylvania, Tennessee, Texas, Virginia, West Virginia and Wisconsin. Full time and part time positions available for career oriented emergency department physicians. Independent contractor status with competitive compensation and paid malpractice insurance. Forward C.V. with availability date and geographic preference to: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795, or in Michigan, 1-800-632-3496.

RHEUMATOLOGIST, board eligible or board certified to associate with internist in expanding medical practice, competitive salary guaranteed with incentive formula, full partnership at the end of one calendar year. Two 400 bed hospitals in city of 100,000, drawing area 150,000. No other rheumatologist in town. Excellent opportunity. Send C.V. and inquiries to Box #2028, c/o *Illinois Medical Journal*. Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OPHTHALMOLOGIST. Part time work with the executive committee of the American Society of Contemporary Ophthalmology. Academic oriented ophthalmologist with good speaking and writing abilities. Excellent opportunity for advancement. Offices in vicinity of Northwestern University Hospital. Call: Virginia Kendall for interview appointment, (312) 951-1400.

WANTED: ILLINOIS licensed physicians to perform life insurance histories and physicals. Also ECG. (312) 763-8744.

MULTISPECIALTY CLINIC. Immediate openings for the following BC/BE specialists in the northwest suburbs: aerospace medicine, dermatology, nutrition, ENT, geriatrics, OB/GYNE, radiology, neurosurgery, plastic surgery, urology. Send resume to Box #2033, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FAMILY/INTERNAL MEDICINE practice available immediately for sale, contract, or partnership in Monmouth, Illinois—population 15,000. Well established, fully equipped. Excellent, friendly family community. Terms negotiable. Reply to Box #2031, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ANESTHESIOLOGIST. An excellent opportunity awaits a board-certified anesthesiologist to join a family-oriented, progressive northwest Illinois community. This community offers good primary and secondary schools, a highly rated junior college, plentiful recreation facilities, a modern 250 bed acute care

hospital with a service area of 54,000 and a satisfying professional and living environment. Attractive financial arrangements. Please respond to: Stephen A. Menke, Vice President, Freeport Memorial Hospital, 1045 W. Stephenson, Freeport, IL 61032.

SITUATIONS WANTED

INTERNIST SEEKS part or full time position: days, evenings, or nights Chicago metropolitan area. Experienced in occupational/industrial and general practice. University trained. Reply to Box #1198, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

WANTED: PRIVATE PRACTICE. General or internal medicine. Chicago or near suburbs. Reply to Box #2019, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED general surgeon seeks suitable position. Willing to do some general practice. Will also consider HMO, minor surgery centers and emergency care centers. Reply to Box #2024, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

WANTED TO BUY: General practice or general practice with surgery. Prefer small or medium size community. Could take over the practice immediately. Has current Illinois license. Reply to Box #2025, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED PEDIATRICIAN seeks part-time position in Chicago and suburbs. Reply to Box #2022, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OB/GYN—BOARD CERTIFIED. Full or part time position. Chicago metropolitan area. Call (312) 267-1471.

FOR SALE, LEASE OR RENT

USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, ultrasound diathermy, surgical instruments, microscopes, etc. Please call or write Robert Shapiro at 512 Warren Road, Glenview, IL 60025; (312) 743-3900.

FOR RENT: Beautiful and well furnished office for rent for any specialty in growing area of Carol Stream, IL. Call (312) 830-3000 after 5:00 p.m.

THREE MONTHS rent free—medical office, super location in Oak Park, great parking. Two exam rooms, 1 office, 1 washroom plus reception area. $495.00. Call (312) 251-3746.

OTOLARYNGOLOGY. Well established practice for sale. Located in the professional building of a 500-bed Chicago suburb hospital. Call (312) 475-2206.

SUBLET OFFICE SPACE for doctor. Fully equipped and furnished-Drs. private office-secretary area-5 exam rooms. Near Archer and Harlem (312) 586-0811.

TWO EXAMINING TABLES for sale. Adult and pediatric with scale. Both have drawers and cabinets. Good condition. $125.00 each. Call Maria (312) 361-0615.

ADR 4000 ULTRASOUND: With linear and sector scanners, extra monitor and cart. Take over lease. For details, reply to Box #2016, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FREE RENT to start. Established medical suite. Furnished or unfurnished. 6450 N. California (corner Arthur). In prestigious air-conditioned medical building. Pharmacy, x-ray, office and complete laboratory on premises. Spacious waiting room and six-day full time experienced receptionists-switchboard operators to handle appointments paid by building. Parking lot. For appt., call: (312) 764-4000 or (312) 338-5089.

FOR LEASE Downers Grove-Established medical center is close to Good Samaritan Hospital. Opportunity for pharmacy, x-ray and doctors. Waiting room recently redecorated. Immediate occupancy. Call Marshall Dunlap; (312) 655-9090.

MEDICAL BUILDING for sale (6,300 square feet) or lease (925 square feet). Formerly chiropractor's office. 1497 Vandalia, Collinsville, IL. Presently divided into seven rooms. Ideal location for a medical office. Close to Oliver Anderson Hospital. Utilities included. Plenty of parking. $700. Call (314) 842-4038.

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

X-RAY MACHINE Universal 300 MA 125 KVP. Stationary table. Upright chest unit. Illinois State nuclear safety approved. New tube. Works perfectly. Ms. Moore, Treister Orthopaedics. (312) 633-5866.

BUSY FAMILY PRACTICE. Southwestern suburbs. Twenty miles from Chicago Loop. $300K gross yearly. Reply to Box #2026, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SELLING FAMILY PRACTICE Southside. Grossing $125,000. Working 3 hours. More potential if fulltime devoted. Selling cheap with equipment. Relocating. Excellent office. (312) 333-6789 evenings/weekends.

ROGERS PARK AREA Radiology practice available. Owner has been grossing $100,000. All equipment included for $47,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312)441-6111.

FOR RENT Medical office for all specialties. Located in Des Plaines. Call (312) 298-1071.

MEDICAL SUITE in busy medical clinic. Centrally located in rapidly expanding population area of Des Plaines, Illinois. Excellent opportunity for specialist or generalist. Share reception with four busy doctors. Introductory list for mailing available. Reasonable rent. Hospitals conveniently located. Des Plaines Medical Arts Bldg., Center and Thacker Streets, Des Plaines, Illinois 60016. Call (312) 824-4919.

ELGIN AREA—Pediatric practice: Owner netting 50% of $400,000 gross. Beautiful offices. Asking $200,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL; (312)441-6111.

PICKER X-RAY: Refurbished and certified equipment (fluoroscopic and diagnostic rooms). Including processor and accessories. In excellent workable condition. Incredible price—due to illness, must sell. Franklin X-Ray, Southfield, Michigan. Please call (313) 358-3410.

SOUTHWEST SUBURBAN (Near Oak Lawn) medical center. Grossing $1,300,000. Owner wishes to stay on, handling his specialty. Well equipped. Write Box #2030, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)244-3355, (312)662-1664.

NEAR NW SUBURB—General practice and real estate. Fully equipped facility, beautifully decorated, grossing $200,000+. Owner retiring. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312)441-6111.

PEDIATRIC PRACTICE for sale. Well established, 30 yrs, 60 miles south of Chicago. Terms negotiable. Contact: Box #2027, c/o *Illinois Medical Journal* Twenty North Michigan Ave., Suite 700, Chicago, IL 60602.

SOUTH LOOP—General practice. Owner anxious to sell, looking for offer. Grossing approx. $200,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312)441-6111.

MEDICAL EQUIPMENT/SUPPLIES For sale/rent. Exam tables, EKG, ultrasound, desks, cabinets, scales, instruments, microscopes,

physical therapy equipment. Trade-ins accepted. Delivery available. Physicians Services, (815)344-3000.

OFFICE SPACE To share: Bright, spacious office in newly remodeled landmark building. 3 exam rooms, large business area and waiting room available. Excellent location on Oak Street. Call (312) 642-9877.

SW CHICAGO (Summit area) General practice. Owner grossing $100,000+. Asking $175,000 for practice and real estate. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312)441-6111.

SOUTHEAST CHICAGO profitable industrial and general medical clinic available. Busy practice grossing approx. $1,800,000. Write Box #2029, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WESTERN SPRINGS SUBLET—Beautiful modern office available 3½ days/week. Hinsdale and LaGrange hospitals nearby. Excellent parking. Call (312) 246-4400.

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PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

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The Value of a Dues Dollar



Every year about this time, we receive our medical society dues, look at the amount and wonder again, "What am I getting for my money?"

First of all, we are a unified state and pay dues to the national, state and county medical societies. Each of these components holds a very important function in organized medicine.

At the national level, the AMA is our "spokesman" with the federal government, trying to safeguard physician interests in all areas of legislation. The AMA is also heavily involved with both graduate and postgraduate education, and is prominently active in the JCAH—the hospital accreditation body. Could any individual, small group or union do nearly as much? I think not!

At the state level, ISMS representatives in our state capital are ever vigilant. Hundreds of pieces of legislation appear each year which could affect physicians. For example, medical malpractice, the Medical Practice Act and discipline bills will be considered, in addition to many bills of more narrow impact but genuine significance to medicine. As individuals, we could not hope to monitor legislation in this way.

The state also sponsors needed services such as the Committee for the Impaired Physician, which has done much good when asked to substitute for or complement impaired physician committees in hospitals. The Office of Contractual Services reviews and interprets alternate health care delivery contracts in "non-legalese" as a free service to members. The state society also provides administrative services for several state specialty societies.

The state medical society offers medical liability insurance to qualified members. And finally, the state society organizes and supports the Professional Liability Initiative (PLI). This mammoth legislative effort, which saw much success in 1985, will continue in the coming year. I do not think we could do all of these things individually or in small groups.

The county medical society helps support the activities of organized medicine at the national and state level, and is also heavily involved in peer review and review-related activities, such as ethical relations and physician review. County societies may sponsor socioeconomic and practice management seminars. They can act as a forum, enabling different groups within the society to express their opinions and discuss differing points of view.

This is just a surface look at what goes on in organized medicine. I am happy to say that we in Illinois participate at all levels, since we are a unified state. We hung on when it was not popular to be unified. But through pressure from your leadership, the AMA has come to recognize and reward the unified state. Following our example, and that of our neighbors in Oklahoma, more and more societies are unifying or discussing it seriously in their state assemblies.

This all costs money, and as a result, the dues level may seem high. But, what organized medicine does for its members also benefits, in many ways, all physicians. Would not our dues bill be a lot smaller if all the freeloaders chipped in to share the economic burden? ◂

Jere E. Freidheim, M.D.
President


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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by David H. Okrent, M.D., and Michael S. Siegfried, M.D., Department of Radiology, Lutheran General Hospital, Park Ridge.

This 37-year-old man reported a persistent cough of two months' duration. A chest radiograph and CT study showed an anterior mediastinal mass. It was a rare primary neoplasm that is associated with ectopic ACTH production causing Cushing's syndrome.

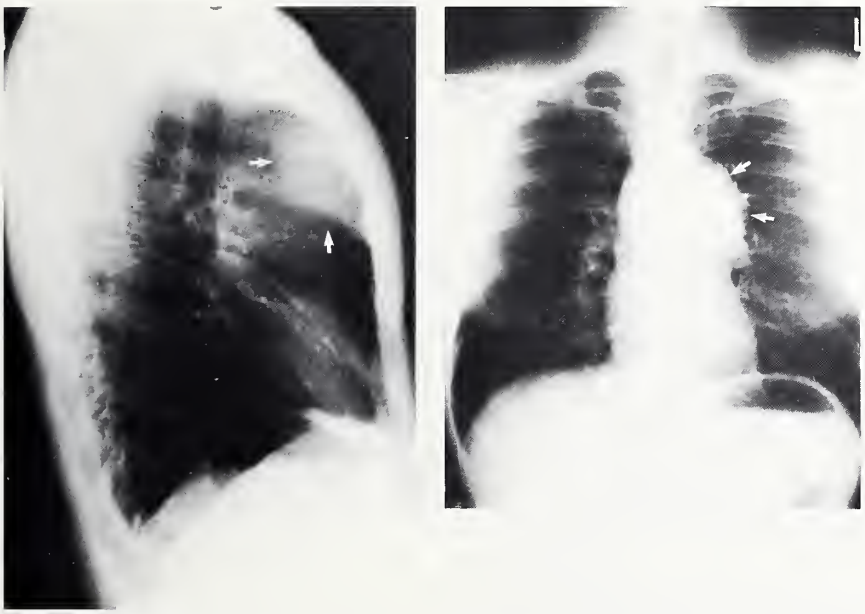


Figure 1
Chest radiographs show an anterior mediastinal mass (arrows).

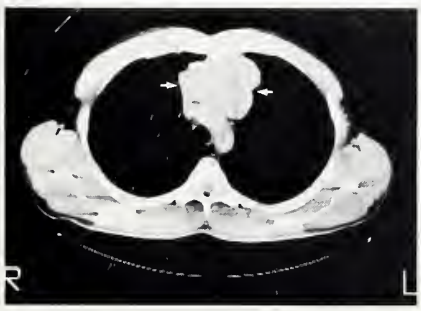


Figure 2
Computed tomography shows a lobulated mediastinal mass (arrows). The lungs were normal.

Your diagnosis?
(1) Burkitt's lymphoma
(2) Thymic carcinoid
(3) Teratoma
(4) Thyroid carcinoma

(Continued on page 351)

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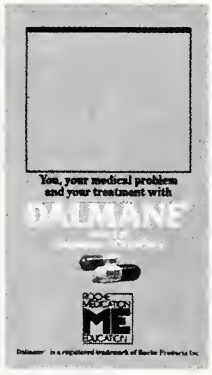
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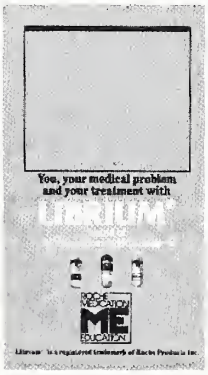
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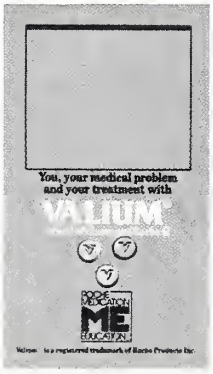
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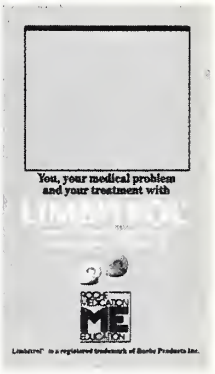
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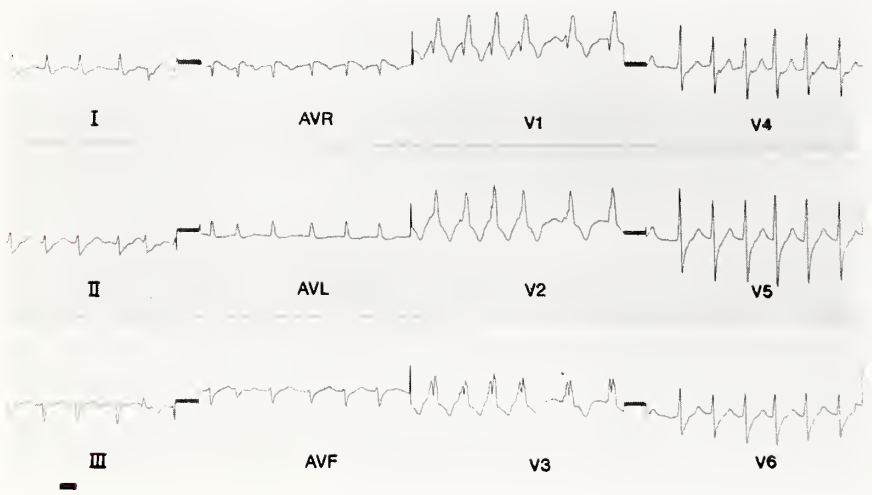
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EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient was a 54-year-old man who had been in good health since an aortic valve replacement 15 years before. The aortic valve had been replaced because of severe aortic stenosis. He had returned to work without difficulty with digoxin, warfarin, and iron sulfate medications.

Six months ago, he had developed postprandial epigastric and retrosternal burning. This was initially relieved by antacids, but the pain gradually worsened. Two months ago, an upper gastrointestinal (GI) tract series, barium enema and ultrasound of the gallbladder were reported as normal. The pain continued to worsen and increased in frequency. A 20 pound weight loss over the six-month period was recorded.

An upper GI endoscopy showed acute gastritis with a friable mucosa. A computed tomography scan revealed thickening of the gastric wall in the fundus of the stomach. A repeat upper GI endoscopy revealed prominent gastric mucosal folds with a small gastric erosion and unremarkable biopsy specimens. Cardiac exam showed a crisp closure sound of the prosthetic aortic valve and a grade 2/6 ejection systolic murmur. The abdominal exam was normal except for some mild tenderness to deep palpation in the right upper quadrant and epigastrium.

An exploratory laparotomy was performed. Five days post-surgery the patient complained of dyspnea, and this 12 lead ECG was obtained. A chest x-ray showed a new right pleural effusion.

Questions:

1. **The twelve lead ECG shows:**
   - A. Ventricular tachycardia.
   - B. Acute anterior wall myocardial infarction.
   - C. Atrial fibrillation with a rapid ventricular response.
   - D. Complete right bundle branch block with left axis deviation.
   - E. Multifocal atrial tachycardia.

2. **The most likely cause of the dyspnea and new pleural effusion is:**
   - A. An acute myocardial infarction.
   - B. An acute bleeding episode secondary to the surgery.
   - C. A bleeding episode related to his preoperative anticoagulation.
   - D. Rheumatic atrial fibrillation.
   - E. An acute pulmonary embolism.

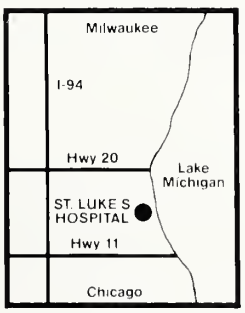
(Continued on page 347)



Dr. Joseph Geenen, Director of St. Luke's Digestive Disease Center.

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Some Good Things Do Come in Small Packages

By Donna M. Weber/Secretary, ISMS-MSS

Traditionally, medical students participate in electives, clerkships and externships at large university-associated hospitals. Recently, another SIU student and I were given the opportunity to design a surgical and autopsy pathology elective which was to take place at a small community hospital in southern Illinois.

We were almost denied participation due to the small size of the hospital. The primary concern of the sponsor was that a facility this size could not generate sufficiently diverse or numerous cases to provide an adequate learning experience. Quantitatively, this viewpoint was certainly a reasonable one, but the statistics did not prove to be an accurate reflection of our learning experience.

These two weeks provided not only a large variety of cases, but also a wealth of personal attention, knowledge and experience. Our time in this community was busy, although we were warned that case load variety was small. While the case load did prove redundant, we were not forced to look at actinic keratosis after actinic keratosis, but were instead challenged with sets of teaching slides, board-style questions, medical decision-making, discussions and questions regarding assigned reading topics.

One hundred percent of our time was spent with the sole pathologist of the hospital. We were introduced to other physicians in the hospital when time allowed, and shown interesting cases from their departments. This gave us a broad view of a small community hospital and its functions. Most importantly, we came to appreciate the rapport between physicians of various departments combined with the strong bonds between the hospital and the surrounding community.

As a native of the Chicago suburbs, I, like our elective sponsor, had my doubts as to what such a small hospital would have to offer in the field of pathology. I didn't realize that what a facility lacks in scope may be replaced in personal attention. The intent of this discourse is not to say that a large institution cannot provide a personal atmosphere, or that a large variety of cases is not important, but instead, that small facilities should not be overlooked. They do, indeed, have something to offer medical students and residents.

There are several reasons to promote smaller institutions to train medical professionals. Students planning to practice in a rural community can benefit from training in a similar environment. Also, the presence of students stimulates communication and continuing education among practicing physicians. Third, Illinois' health manpower shortage areas need physicians, and residency programs could encourage long term commitments in these communities.

Clearly, these programs offer something of value to student and community alike. My self-designed elective was an extraordinary experience, and from it this suburbanite learned that some very good things do come in small packages. ◀

THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Introduction to a Mindset

Alternative delivery systems, such as HMOs, IPAs, PPOs and others, are new. They may be similar, but few are identical. Knowledge, research and thoughtful, inquiring deliberation is required. Each contract decision made by the informed physician is made with a cautious and keen eye. In short, when weighing a contract, the informed physician must combine the caring attitude and sharp intellect of a physician with the prudent mind of a business person.

The financial and legal issues presented in HMO, PPO, and IPA contracts are new to most of us. If you're baffled or perplexed by a contract, one thing is certain: You're not alone.

For example, an IPA (Individual Practice Association) is a type of HMO. There is no common HMO facility or site; IPA physicians treat HMO contract patients in their private offices. Generally speaking, the HMO pays the IPA a fixed amount per month, per person enrolled in the HMO/IPA. The IPA pays for covered health care services used by HMO contract patients from monies received from the HMO.

Suppose you're one of the IPA directors. One fundamental question may be whether the IPA can pay for good quality health care from the monthly payments it receives from the HMO. Another question may be whether the cost of stop loss and contingent liability insurance are paid for by the IPA or the HMO. The IPA may also wish to research whether the occupational groups that make up its HMO contract patients are statistically known to utilize some health care providers and facilities more frequently than others. Whether the number of contract patients in low risk age groups is sufficient to offset the number in high risk age groups may also be pertinent.

HMO and PPO utilization review and quality assurance programs present new legal, insurance and "standard of care" issues that are generally not encountered in the traditional fee-for-service medical practice. Because good quality patient care depends on proper utilization, an understanding of the issues is imperative.

Let's assume that you are not a hospital administrator, you don't work for an insurance company and you don't know what an actuarial assumption is. Happily, contact with attorneys has been limited to your house closing and the signing of your will. You may be thinking about either forming or joining an established IPA. Or you may be on the board of directors of an IPA that is considering one or several contracts being offered by either start-up or established HMOs, and your board must make the final decisions and live with them.

You may have little direct experience, but you *are* an informed physician. You know what questions to ask, what issues need to be resolved and when it's time to consult an attorney, accountant or actuary.

Knowledge is power for the informed physician, so your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

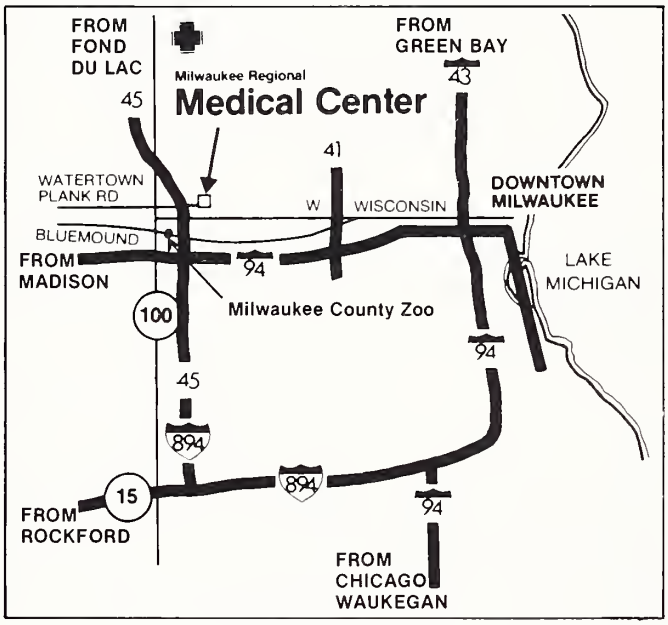
The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an *Individual Participation Agreement* with an HMO, PPO, or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates anti-trust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

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A Rheumatology Practice in a Community-Based Medical School

By Muhammad B. Yunus, M.D., N. Aisha Kudmani and Alfonse T. Masi, M.D./Peoria

Frequency of rheumatic diseases in the rheumatology clinic of a community-based medical school and patient response regarding various aspects of care were studied. Osteoarthritis (OA), rheumatoid arthritis (RA) and primary fibromyalgia syndrome (PFS) were most frequently seen; connective tissue diseases were uncommon. A majority of patients were highly satisfied with their management; no significant differences were found between OA, RA and PFS groups. Self-assessed functional capacity was initially poor among OA, RA and PFS patients, but significantly improved in all groups after a mean interval of 16 months.

Although several reports on the practice of rheumatology have been published,[1-7] none have described a community-based medical school practice or patient attitudes about rheumatology services. Prevalence of rheumatic disease in community practice is important, because of implications on health services delivery, research, and education. Similarly, knowledge of patient response in treatment satisfaction, compliance, medical student participation, and physician fees is useful in planning more effective services.

Patients and Methods

Charts of patients seen in rheumatology consultation at our community-based medical school over two 12 month periods, January to December 1979, and July 1982 to June 1983, were reviewed. Age, sex, diagnosis, referring physician's specialty and location of patient residence were included in the study protocol. Although original diagnosis rarely changed on follow-up visits, the final diagnosis was used. A simple self-administered questionnaire was designed with the help of a psychologist. The questionnaires were mailed to the 285 ambulatory patients seen during the first year. Requested information included degree of satisfaction with: medical management, improvement from treatment provided by the rheumatologist as compared to previous treatment, physician fees, and medical student/resident participation in patient evaluation. Compliance with medication and exercise recommendations and degree of functional capacity were also studied. Functional capacity was broadly assessed by the question, "What was your ability to perform your job and carry out home activities before visiting our clinic?" A similar question was asked regarding functional abilities at the time of response. All questions were scaled from one to five. Questionnaires were sent by mail and returned anonymously, in order to minimize responder bias.

Results

Disease Frequency

The relative frequency of rheumatic diseases seen in our ambulatory center among 285 new patients during the first assessment period and 531 during the second is shown in Table 1. Osteoarthritis (OA), rheumatoid arthritis (RA) and primary fibromyalgia syndrome (PFS) were the three most common conditions reported in each period. Disease frequencies differed significantly between the first and later years only for the OA ($P < 0.005$) and "others" categories ($P < 0.001$). (Table 1) No single disease seems to have contributed significantly to the larger number of "others" during 1982-83. The proportion of juvenile RA patients was higher (3% in the later year as compared to 1.4% in 1979) but this difference is not statistically signifi-

Table 1
Relative Frequency of Diagnoses Among New Patients (Consultations seen during January-December 1979 and July 1982-June 1983 in an ambulatory rheumatology clinic.)

Diagnosis	1979 (n = 285)		1982-83 (n = 531)	
	Number	(%)	Number	(%)
Osteoarthritis	83	(29)	96	(18)
Primary fibromyalgia syndrome	54	(19)	88	(17)
Rheumatoid arthritis	45	(16)	104	(20)
Soft tissue rheumatism other than PFS	27	(9)	38	(7)
Spondyloarthropathies	23	(8)	28	(5)
Systemic lupus erythematosus	8	(3)	17	(3)
Other connective tissue diseases*	9	(3)	35	(7)
Others	36	(13)	125	(23)
Total	285	(100)	531	(100)

**These include scleroderma, poly(dermato)myositis, mixed connective tissue disease, Sjogren's syndrome, polymyalgia rheumatica and vasculitis.*

Table 2
Percent Frequencies of Questionnaire Responses Among the 191 (67%) of 285 New Patients Seen During 1979

Questionnaire Items	Degree of Response (%)			
	High	Mod.	Low	Not Stated
Patient satisfaction with:				
Physician at initial visit	82	10	7	1
Physician at response time	60	22	15	3
Physician fees	66	14	16	4
Medical student/resident participation	67	11	5	17
Compliance with:				
Medication instructions	63	6	15	16
Exercise directions	35	23	20	22
Understanding of:				
Disease condition	86	8	5	1
Medication instructions	89	4	0	7
Exercise directions	79	6	2	13
Help from new treatment compared to previous treatment:	55	16	14	15
Functional capacity:				
Initially	20	40	40	0
At response	55	37	7	1

cant. Other soft tissue rheumatism (STR) conditions, including bursitis, tendinitis, localized fibromyalgia and low back sprains, were common in both periods studied, followed by spondyloarthropathies (SA). Individual connective tissue disorders (CTD) were relatively uncommon in both periods.

Referring Physician's Specialty and Patients' Residences

During 1979, family/general practice physicians referred the largest number of patients (50%), followed by internists (14%) and orthopedic surgeons (10%), with the remainder (26%) referred by other physicians. About 36% were from the city of Peoria, 37% from the tri-county area (within 38 miles of Peoria) and the remaining 27% from outside the tri-county area, roughly reflecting population distributions. These variables were not analyzed for the patient population of 1982-83.

Patient Satisfaction, Responses, and Functional Capacity

Information on these variables was collected only on 191 (67%) of the 285 new patients seen in 1979 (Table 2). We used a one- to five-point grading scale; grades four and five were scored as "high," three as "moderate," and one and two as "low." Eighty-two percent of respondents were highly satisfied with their initial rheumatologist visit. After a mean follow-up period of 16 months, 60% still expressed high satisfaction at the time of response. Frequencies of high degree satisfaction among patients with the three most common conditions (OA, PFS, and RA) did not differ statistically.

Fifty-five percent of patients believed that the treatment following rheumatology consultation greatly helped them as compared to the treatment they had received previously, and another 16% reported such comparative help of moderate degree. The majority of patients (78%) did not mind being examined by a medical student or a resident prior to attending physician's review and evaluation. Only 16% were dissatisfied with the initial physician consultation fee, although another 14% were only moderately satisfied. Only 35% claimed to follow the demonstrated exercise instructions very regularly. Sixty-three percent stated that they took their medications regularly and 89% indicated that they understood the physician's medication directions well. An understanding of the rheumatic condition scored high in 86% of respondents.

Good (high) functional capacity was indicated initially in only 20% of patients, but increased to 55% after a post-consultation mean interval of 16 months ($P < 0.001$)

(Table 2). Poor functional capacity was present initially among 42%, 44% and 48% of OA, PFS and RA patients, respectively, and the corresponding figures decreased to 18%, 5%, and 17%, respectively, after a post-consultation mean interval of 16 months (OA: $P < 0.05$; PFS: $P < 0.001$ and RA: $P < 0.05$).

Discussion

This report of our rheumatology practice over two 12-month intervals is based on ambulatory consultations in a community-based medical school. To our knowledge, experience describing an academic institution and a community integrated private practice had not been previously reported.

The most commonly encountered rheumatologic conditions were OA, RA, PFS, and other forms of soft tissue rheumatism, corresponding with national health interview survey data.[8] Recent communications by Mazanec[6] and Alarcon-Segovia[7] describe rheumatic disease frequencies in urban private practice settings with results similar to ours. Soft tissue rheumatism (STR) entities are very common, while connective tissue diseases are uncommon in U.S. rheumatology practices,[1-3,6,7] including ours, as well as in the general population in Sweden.[4] STR disorders were the most common,[1,5] or third most-common conditions seen in community-based practices.[2,3]

Among non-articular rheumatism disorders, primary fibromyalgia syndrome (PFS) is of particular interest due to its recent characterization,[9-12] frequent misdiagnosis and mismanagement,[9] and significant degree of functional incapacity. Most physicians do not recognize the syndrome,[9] and even rheumatologists are likely to underreport it. In our practice, PFS was the second or third most-common condition. It appears unlikely that this frequency was significantly influenced by referral bias, since two recent communications report "fibrositis" to be the second (16%)[6] and third (15%)[7] most common diagnoses, respectively, in private rheumatology practices in two large cities.

Most patients claimed a high degree of benefit from our treatment, as compared to the previous treatment of their referring physicians. A high degree of satisfaction with their initial visit was reported by 82% of respondents, although this response after a mean interval of 16 months fell to 60%. Such degree of satisfaction for either response compares favorably with the national average,[13] which showed that 54% of Americans are "very satisfied" with their doctors. Our data are likely to be unbiased, since all questions were distributed and responses returned anonymously.

Degree of satisfaction did not differ significantly among the three common patient groups (OA, PFS and RA). Self-assessed functional improvement was significant and impressive over the time period studied. Overall, 40% had poor functional capacity initially, whereas only 7% reported this degree of poor function after a mean interval of 16 months.

Most patients (78%) did not object to being interviewed and examined initially by a medical student or a resident in a private practice setting (Table 2).

Results of this simple questionnaire survey must be qualified. It was designed to collect only *general* response data on patient behavior and satisfaction and cannot be compared with those of other in-depth, structured studies.[14-17] However, global response on functional capacity or satisfaction correlates well with multiple, in-depth questionnaire items assessed by Health Assessment Questionnaire and Arthritis Impact Measurement Scales.[14-16,18] Interestingly, our general questionnaire on drug compliance yielded the same results (63% with high compliance) as did a more detailed study.[19] Compliance with exercise instructions among our patients was poor (35%). Further research and attempts to increase patient compliance with drug and exercise recommendations is warranted.

In conclusion, this report concurs with other recent publications on the frequency of rheumatic diseases in a community-based rheumatology practice, showing that non-articular rheumatism, osteoarthritis, and rheumatoid arthritis are the most common rheumatologic conditions. Responses in this preliminary survey provide a general indication of patient satisfaction and should be further studied by more critical, in-depth methodology.

References

1. The American Rheumatism Association Committee on Rheumatologic Practice: "A Description of Rheumatology Practice," *Arthritis Rheum* 20:1278-1281, 1977.
2. Bohan, A.: "The Private Practice of Rheumatology," *Arthritis Rheum* 24:1304-1307, 1981.
3. Epstein, W.V., Henke, C.J.: "The Nature of U.S. Rheumatology Practice, 1977," *Arthritis Rheum* 24:1177-1187, 1981.
4. Bjelle, A., Allander, E., Mägi, M.: "Rheumatic Disorders in the Swedish Population and Health Care System," *J. Rheumatol* 7:877-885, 1980.
5. Bjelle, A., Mägi, M.: "Regional Rheumatology Practice in Umea—A Northern Swedish Experience," *J. Rheumatol* 8:110-118, 1981.
6. Mazanec, D.J.: "First Year of a Rheumatologist in Private Practice; (letter) *Arthritis Rheum* 25:718-719, 1982.
7. Alarcón-Segovia, D.: "One Thousand Private Rheumatology Patients in Mexico City", (letter) *Arthritis Rheum* 26:688-689, 1983.
8. Masi A.T.: "Perspectives of Arthritis and Rheumatic Conditions," *Continuing Education* 8:17-19, 1978.
9. Yunus, M.B., Masi, A.T., Calabro, J.J., Miller, K.A., Feigenbaum, S.L.: "Primary Fibromyalgia (Fibrositis): Clinical Study of 50 Patients with Matched Normal Controls," *Sem Arthritis Rheum* 11:151-71, 1981.
10. Campbell, S.M., Clark, S., Tindall, E.A., *et al:* "Clinical Characteristics of Fibrositis," *Arthritis Rheum* 26:817-824, 1983.
11. Smythe, H.A.: "Non-articular Rheumatism and the Fibrositis Syndrome," Arthritis And Allied Conditions, eighth edition. J.L. Hollander, D.J. McCarty, Jr., Eds. Philadelphia, Lea & Febiger, p. 874-884, 1972.
12. Wolfe, F., Cathey, M.A.: "Prevalence of Primary and Secondary Fibrositis," *J Rheumatol* 10:965-968, 1983.
13. Taylor, H.: "American Attitudes Toward Health Maintenance Or-

ganizations," Louis Harris and Associates, Inc., New York (study no. 794021/second edition).
14. Pincus, T., Summey, J.A., Soraci, S.A., Wallston, K.A., Hummon, N.P.: "Assessment of Patient Satisfaction in Activities of Daily Living Using a Modified Stanford Health Assessment Questionnaire," *Arthritis Rheum* 26:1346-1353, 1983.
15. Meenan, R.F., Gertman, P.M., Mason, J.H.: "Measuring Health Status in Arthritis: The Arthritis Impact Measurement Scales," *Arthritis Rheum* 23:146-152, 1980.
16. Fries, J.F., Spitz, P., Kraines, R.G., Holman, H.R.: "Measurement of Patient Outcome in Arthritis," *Arthritis Rheum* 23:137-145, 1980.
17. Liang, M., Jette, A.: "Measuring Functional Ability in Chronic Arthritis," *Arthritis Rheum* 24:80-85, 1981.
18. Brown, J.H., Kazis, L.E., Spitz, P.W., Gertman, P., Fries, J.F., Meenan, R.F.: "The Dimensions of Health Outcomes: A Cross-Validated Examination of Health Status Measurement," *Am J Public Health* 74:159-161, 1984.
19. Deyo, R.A., Inui, T.S., Sullivan, B.: "Noncompliance with Arthritis Drugs," *J Rheumatol* 8:931-936, 1981.

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Management of Accessory Nerve Injury

By Lawrence N. Gray, M.D., Sidney J. Blair, M.D., and Nolan S. Lewis, M.D./Maywood

A 28-year-old white male reported neck pain and inability to perform normal lifting with his left arm. Left trapezius muscle activity was absent; muscle atrophy and marked restriction of active abduction and elevation of the left arm were also noted. (Figure 1) A well-healed 3cm incision in the left posterior cervical region was also found.

Seven weeks earlier the patient had been hospitalized with low back pain. An asymptomatic left posterior cervical lymph node had been found and biopsy had revealed reactive changes believed secondary to dental infection. The patient noted limitation of the left shoulder and neck pain. Three weeks later an electromyography and nerve conduction test revealed absent motor activity of the left accessory nerve and fibrillations of the left trapezius.



Figure 1

The patient was scheduled for surgery the following week and instructed in use of a muscle stimulator to prevent further atrophy. Exploration revealed that the nerve was embedded in scar tissue. The nerve stimulator evoked muscle contraction following nerve mobilization and external neurolysis. The patient's neck pain and left trapezius difficulties resolved, and he returned to work. (Figure 2)



Figure 2

Discussion

Accessory nerve injury is the most frequent major complication of posterior cervical triangle surgery. Iatrogenic injuries during surgery probably represent the most common cause of accessory nerve palsy. This result has also been reported with cannulization of the internal jugular vein,[1] human bite injury,[2] malignancy,[3] hockey stick injury,[4] and unsuccessful hanging.[5]

Injury frequently occurs when the surgeon does not appreciate the superficial course of the accessory nerve in the posterior cervical triangle, where it lies under skin and fascia only, adjacent to lymph nodes. The nerve may be injured by laceration, cautery, ligatures, traction, adjacent scar tissue, or deliberate choice during a radical neck dissection.

Injury may result in cervical or shoulder pain. The trapezius muscle atrophies and the patient experiences restricted active shoulder abduction, a dropped shoulder, and a winged scapula.

The surgeon can prevent surgical insult by identifying the accessory nerve where it emerges from the middle of the posterior border of the sternocleidomastoid and following it distally.[6]

Electromyography and nerve conduction tests may be employed to evaluate suspected accessory nerve injury following surgical trauma. The findings will determine whether nerve injury should be repaired by microsurgical nerve repair, nerve graft, or neurolysis. Physical therapy alone is unrewarding. ◀

References

1. Hoffman, J.C.: "Permanent Paralysis of the Accessory Nerve After Cannulization of the Internal Jugular Vein," *Anesthesiology* 58:583, 1983.
2. Paljarvi, L., Partanen, J.: "Biting Palsy of the Accessory Nerve," *Journal of Neurology, Neurosurgery, and Psychiatry* 43:744, 1980.
3. Wright, T.A.: "Accessory Spinal Nerve Injury," *Clinical Orthopedics* 75:15, 1975.
4. Bateman, J.E.: "Nerve Injuries About the Shoulder in Sports," *Journal of Bone and Joint Surgery* 49:785, 1967.
5. Singh, S., Schlagenhauff, R.E.: "Pressure Palsy of the Accessory Nerve," *Neurology of India* 19:122, 1971.
6. Grant, J.C.B.: An Atlas of Anatomy. Sixth Ed. Baltimore, Williams and Wilkins, 1972.

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Second of Two Parts

In Pursuit of Professional Freedom

Saul J. Morse, J.D., the principal of Saul J. Morse & Associates, Ltd., a Springfield law firm concentrating in governmental, health and administrative law, has been legislative counsel to the Illinois State Medical Society since 1977.

Mr. Morse has served as minority legal counsel to the Illinois Senate and a trial attorney before the U.S. Interstate Commerce Commission. He is a member of the Illinois Human Rights Commission, vice-chair of the American Bar Association Medicine and Law Committee of the Tort and Insurance Practice Section and a member of the Illinois State Bar Association Committee on Insurance Programs.

Our September issue carried part one of this interview, "Revolution Comes Slowly to the Law," which focused on the medical malpractice reforms passed in 1985 and the Illinois Supreme Court ruling on their constitutionality. This month we present the conclusion, covering comments on the Society's legislative agenda and the overall philosophical thrust of the Professional Liability Initiative.



IMJ: *Why do you think the 1985 malpractice reform effort was successful? And why do caps on non-economic awards and a more reasonable statute of limitations for minors remain outstanding?*

Saul Morse: The reforms passed because action teams in local communities had been working hard for a year or more to bring the issues into focus in the public mind. Action team leaders were sharing their concerns and meeting with legislators back home in the districts—which is more important than meeting with them in Springfield. They were pointing out the local effects of this problem. They were talking about the availability of quality care to consumers. They were showing concrete evidence that the malpractice crisis was a real problem for voters in the district.

The health care community came forward with anecdotal evidence, solid examples that weren't just horror stories. Legislators came to realize that these were not isolated and bizarre lawsuits; they were actions of increasing frequency changing the fabric of the tort system. That was terribly important.

I think the role of the leadership in alerting the membership and putting a strategy together was important. It's clear from the results of 1986 tort reform, when a statewide coalition of over a hundred groups got substantially less than we got on behalf of one relatively small but potent group.

Physicians represent a small proportion of the citizens of Illinois—something like 25,000 of 11 million people. When you compare the size of the health care community with the aggregate of all the municipalities, manufacturers, chambers of commerce, park districts, the libraries, and everybody else involved in the '86 effort, you see how crucial the action teams, the leadership, and the determination of the rank and file physician proved to be.

The majority of the legislators

would have done something; but they wouldn't have done this much without the grassroots campaign. That's clear from the 1986 results, which were passed after the Supreme Court had already ruled. The Supreme Court ruled on June 20 and that legislation was considered on June 30. A lot of the arguments as to constitutionality and people's rights had gone by the boards.

The legislators are used to seeing me and other people on the Society staff. We get along extremely well. But a legislator knows that, wonderful though they may be, lobbyists are being paid to do their job. Documenting that this was really a gut issue with the membership convinced them that the malpractice crisis was real.

That rally in May of 1985 was just incredible. It's difficult to oversell the importance of 4,000 or 5,000 people from one profession coming down and saying, "We've got a problem. It's real. We're here. We're on the line. We're ready to show you that it really is a problem." Especially when you consider that if there are 25,000 physicians in this state, you're talking about roughly 20% of an entire profession coming to Springfield to plead their case.

I think that was the straw that broke the camel's back. The rally was the crescendo of an effort that said to legislators, "We can't duck this. We can't delay it. What we do has to be real. It has to be significant. This is important. We're talking about quality of care here. We're talking about what the malpractice crisis does to individual citizens and the quality of life in the state. We're talking about what it does to the business climate."

I think all of this shows the importance of rank and file effort. It shows that any future success will be rooted, not solely but certainly significantly, in the extent to which it is membership-driven.

I think all of this shows the importance of rank and file effort. It shows that any future success will be rooted, not solely but certainly significantly, in the extent to which it is membership-driven.



IMJ: *What's it going to take to convince legislators that we need caps on noneconomic awards?*

Saul Morse: The report of the Governor's Task Force on Medical Malpractice said that caps were the one thing that would seem to have the most clear cut effect on the insurance problem. But it's also one of the most difficult gut issues. It's very difficult to tell a jury that they can't award whatever they feel is deserved. Pain and suffering—noneconomic damages—are so subjective. People have been awarded two million dollars in pain and suffering when it can at least be argued that they're just not going to suffer that much. And people have been awarded $20 in pain and suffering when you know there is some genuine deprivation. That's what makes it a bad situation. That's what makes it tough to deal with.

I think that the issue of caps will be at least as difficult, if not more so, than the task in 1985. Remember, we asked for caps then, and a number of legislators made it very clear that there was no way they could support anything we pushed for if we pushed for that.

IMJ: *There were plenty of obstacles to the 1985 legislation, but most of them were overcome. Caps didn't pass in 1985. Why did this issue stand out?*

Saul Morse: The large pain and suffering cases—the large dollar volume cases—are few in number but very, very significant. Those are the kinds of cases that tear at everybody's heart strings. How do you set a value on a child who is brain injured and will always require constant care? How do you set a value on a parent in his or her 30s or early 40s who is so severely disabled as to be unable to care for the family? I don't know.

That doesn't say the sky's the limit. It's just as wrong to give someone too much as it is to give them too little. We can't afford to take the case out of context.

IMJ: *What do you mean when you say that we can't afford it?*

Saul Morse: Our society has a system which depends upon availability of resources—medical resources, legal resources, financial resources. They have to be there for everybody. And if the system slips too far to one extreme for one person or group of people then, by definition, it's not available to the majority of us. I don't think it's heartless or cruel to talk about appropriate limitations, but it's hard to get there.

It's just very difficult to get people to that position, because all of us, when we see somebody with truly significant problems or limitations, want to help them get what they need. We all have that response. It's difficult to bring people to accept the reality and say, "Yes, but we need to have care available for the next child who is going to be born in a difficult delivery. And we need to have care available for the next parent in his or her 30s or 40s who comes into a physician's office or hospital with a problem—significant or relatively routine."

We need to have physicians available to treat those people and to have the flexibility of judgmental decision-making. That's what physicians as professionals are trained to do. We can't have cookie cutter medicine. And for the very same reasons, we can't have cookie cutter law.

The professional in any discipline has always been marked by the ability to form judgments and to act on the basis of training and gut instinct. The moment a professional loses that flexibility, we all suffer a potentially irreparable harm. That may be truer in medicine than in any other field. It's difficult to say that and it's difficult to show. It's difficult to explain that problem to



legislators, who are besieged with new offerings of competing health insurance plans making it seem that there are all kinds of doctors available out there. They read stories about a surplus of doctors. They read stories about hospitals operating at 55-60% occupancy. And they're likely to say, "Wait a minute. Is this really a social problem? Does this really affect all of us? Or is it just that you don't want this poor injured person to have everything they need?"

IMJ: *That ties into the whole debate about experimental procedures and access to care. Maybe it's all of a piece. How does a society regulate what cannot help but seem to be arbitrary decisions made on the basis of professional judgment? How can a society move forward without professional freedom?*

Saul Morse: Whether we vote at 18 or 21 is arbitrary. Whether we get to drink at 18 or 21 is arbitrary. Whether we drive at 16 or 18 is arbitrary. That's what government's for.

Government provides the framework within which we go out and disagree with each other. One thing we focus on is the extent to which that framework incorporates a quality health care system whose professionals are able to render the kind of care that they have been trained to give. Our society gives its professionals the right to work within a framework of professional freedom. That doesn't say that you're free from responsibility, or that you're a god and nobody can touch you. The given in a free society is that to the extent you utilize your best professional judgment and operate in a reasonable and appropriate manner, you will be able to practice your profession. It's a given with the understanding that we're dealing with crucial issues here. And the understanding that none of us are perfect.

Since none of us are perfect, it is by definition unreasonable to expect perfection from anyone. That includes the court system and it includes physicians. It includes legislators, teachers, and all other humans.

To a large extent, we have come to expect perfection. We have to get away from that, I think. Nowhere is it written that life will be fair. It will be appropriate, we hope, but it won't be fair. People have to understand that. It would be nice if every baby born this year could go to Harvard Law School or Johns Hopkins Medical School or whatever is the absolute best. But it isn't going to happen. That limitation is no more or less unfair than the fact that twelve people are expected to assign specific compensation for injuries which do not lend themselves to a real valuation. There's just no way to place a value on pain and suffering.

IMJ: *How should we approach the legislature on this issue?*

Saul Morse: It will be decided as a big picture question, so it's important to approach it from that perspective. It's important to point out that you can't look at the grievously injured and make a judgment on the basis of the heart rending picture of one badly injured person.

The report of the Governor's Task Force on Medical Malpractice said that caps were the one thing that would seem to have the most clear cut effect on the insurance problem.

You have to put it into context. Noneconomic damages have to be viewed in terms of overall health

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care availability and quality. It's like the vaccine problem. Should society choose to have vaccine available to innoculate a million babies for diphtheria, realizing that maybe three or four of them will have a reaction which may or may not be serious? Or should we withhold the vaccine because three or four of them might have a reaction, and run the risk of a diphtheria epidemic and everything that goes with it? If we made all our decisions on the basis of whether or not somebody may be hurt, a lot of beneficial things would never happen. Columbus wouldn't have left Spain. The Wright Brothers wouldn't have flown at Kitty Hawk. The advances in society in general and medicine, in particular, wouldn't have happened.

The American mentality is and always has been that the individual should not hesitate to take risks. Americans try. We dare to do something. It's not our mentality, as a society, to take the safe and easy route. World history has shown a sense of risk-taking and adventure. If we didn't have that, we'd be having this discussion around the Euphrates River or the Nile.

People can be hurt when risks are taken. Sometimes because of their own fault. Sometimes through no fault of their own. But at some point we have to weigh all the factors and look at the big picture.

IMJ: *What do you think is the strongest logical argument for caps on noneconomic losses?*

Saul Morse: I think it's important to emphasize that we're not talking about economic damages. Someone who can show $20 million in economic damages, lost wages, the need for a caretaker, the need for medications, hospitalization, durable medical equipment or whatever, should be fully compensated. We're not talking about those readily quantified things. We're talking about an ephemeral element, pain and suffering. How different would your life be had this not happened to you? That's one point that should be made: we're not talking about limiting economic awards.

It's also important to stress that while an injured person may encounter problems, those limitations do not make them useless individuals. These people can be vital, contributing members of society in their own way. It's important to remember that. There will be some people, who, for whatever reason, will be almost unable to function. But the mere presence of a significant health or physical problem does not, *per se,* render you vegetative and useless. This has to be stressed.

IMJ: *How should our members structure their arguments for a more reasonable statute of limitations for minors?*

Saul Morse: It's important to point out that in most instances people become aware of a problem within the two to four years that our statute provides for adults. That's two years from when you discover the problem but in no event more than four years after the onset. Children—and again, we're talking about a medical problem here—have more medical checkups than adults. When they're infants they see a doctor every three months. They're growing more. They're changing more. They tend to get more care. If they tend to get more care than adults, why is it that they absolutely need all this extra time to bring a lawsuit? I would submit that while there are some valid policy reasons, one of the reasons is to protect parents or guardians who don't pursue their rights promptly. I'm not sure that's so appropriate as to be untouchable.



We can't have cookie cutter medicine. And for the very same reasons, we can't have cookie cutter law.

People should understand that if



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you wait 22 years, it'll be more difficult to bring a case because records won't be there. People won't be available as witnesses. It's often said that justice delayed is justice denied. It's true whether you're 44 or 4. People have to understand that.

I don't know yet exactly what shape legislation might take. The Board of Trustees, after referral to the appropriate councils and review and the like, comes up with a proposal that the Society supports.

For argument's sake, let's take some legislation which passed in other states and was the subject of a resolution at this year's annual meeting. It called for a six-year statute of limitations for minors.

Six years is still 50% more than adults. How many problems are so difficult to determine that you won't know that there is in fact a problem in six years? Is it unfair? That's the thing a legislator has to keep asking. Is it unfair? I would submit to you that I don't think that it is unfair when you look at it in that light.

Admittedly, there are some problems which don't manifest themselves right away, but we're not talking about a significant number. How fair is it to everybody to take that long? If there is a problem in health care for a child, doesn't society benefit if that problem is brought to light immediately? If there was negligent or inappropriate care, the profession should become aware of it promptly and make the changes that are needed.

Look at some of the medications that were used in the '50s. Look at what we knew about x-rays back in the '40s. How much better would it be had we known about those things within two or three or four years?

I'm not saying everything lends itself to that. But society benefits when we find out about these things more quickly. When we know what the appropriate dosage is. When we know what the proper course of treatment is. There's a societal benefit to dealing with these things quickly.

History has shown that medicine responds quickly when there's a need. Not just in attempting to address a new health problem, but in seeking a new course when a prior course of treatment is shown to be wrong.

Medicine is a little more revolutionary than law if you look at the care given today as contrasted with the care given 30-40 years ago. The procedures we have, the new equipment, things like CAT scans and replacement joints for hips and knees. In medicine, somebody comes up with an idea and improves it and fine tunes it and changes it and watches the reaction. That's a revolutionary mileu.

Look at what's happening today. Consider just the last ten years in genetic research, or medication. Look at the people today. Quadriplegics are alive today who would have died five or ten years ago. We didn't have the equipment then. We didn't have the response time. When you compare the injured soldiers who survived World War I to those who survived World War II, and then to those who survived Vietnam, you see incredible increases in the number saved. No one would have thought that possible a hundred years ago. Look at the people who died from the flu around the turn of the century and then consider the number who die today. Medical progress is evolutionary. But it only happens when everything clicks.

IMJ: *The environment must nurture its evolution.*

Saul Morse: In a progressive environment, problems in experiments and mistakes which may result from negligence are quickly shown and corrected so that they don't happen to somebody else. The biggest thing to come out of malpractice litigation is that when physicians have been shown to be negligent, the rest of the medical community has had a great opportunity to evaluate what was done and determine whether there ought to be a change in the way they provide care. That's the evolving standard of care.

IMJ: *This spring, we attempted to introduce major amendments to the Medical Practice Act which incorporated the recommendations of the Governor's Task Force on Medical Discipline. That legislation never came to a vote. Do you think there will be positive, effective action on medical discipline in the next session?*

Saul Morse: I think there will be positive action in '87. It will be incredibly difficult. This spring, the Governor's task force came out with its report recommending significant changes, changes which would put Illinois in the forefront among the states. When physicians talk to their legislators, they ought to point out that physicians led the effort to toughen discipline. It shows the real concern for quality care. Physicians are not just looking to make it harder to sue. They're saying, let's have the valid suits, but let's also have a good, appropriate disciplinary system so the problems can be identified and addressed.

This year, the legislature did almost nothing. And, it was, frankly, the most boring session I've ever gone through. The legislature, this year, was to deal with emergencies and budget messages only. The even numbered years are supposed to be limited to that. Now an emergency is whatever the legislature decides is an emergency. But it was a low-key session in many respects, and that made people respond to the discipline proposals by saying, "Look, is this really necessary this year? Does it qualify as an emergency?" It was at least as much an emergency as a lot of other things that passed. We were so successful in '85, that I think there was a tendency for the legislators to say, "Don't you ever relax? Enough already."

The other thing that made a difference, frankly, is that the Medical Practice Act was scheduled to sunset in 1987. Now, what that means—and this is terribly important—is that the legislature has to make a policy decision as to whether or not there needs to be regulation of medicine, and if so, how to do it. We have a law which hasn't been through a total rewrite in 63 years.

It's often said that justice delayed is justice denied. It's true whether you're 44 or 4.

There've been changes, certainly. It's an ongoing thing. But a total rewrite and reevaluation hasn't occurred in 63 years. There were legislators who said, "We're supposed to do all of this next year. Let's hold hearings. Let's evaluate our Medical Practice Act. Let's see what's available out there. Let's not rush into it."

Some were concerned about allowing sufficient time for thorough evaluation and review through the committee process. Some of them, frankly, would like to see changes in the way physicians practice. Some of them, I think, want to see changes in the educational requirements. Changes in the way in which medicine is practiced on a day-to-day basis and changes in discipline. And some want to see more active involvement and autonomy for allied health providers. We have to be aware of the people out there who want that.

We have seen revolutionary changes in what hospitals are doing today and in the way health care is being delivered and who's delivering it. Some people are saying, "Can't some of the things that physicians do be done by others?" And

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these people wanted to make sure that this was reviewed at an important time, a time when there wasn't an election coming up and it would be given careful consideration. And a time when the Medical Practice Act was going to expire, and everyone would have to at least consider compromise. We need a Medical Practice Act. It would be horrendous to think of a day when there was no Medical Practice Act and anyone could say, "I'm a physician. I'll care for you." The public needs to be protected.

Important provisions in the law which have been won by physicians over the past 50-60 years must be protected. We're talking about gut issues here—the license to practice and what it means. There will be people out there saying, "We want to put our two cents' worth into this. Physicians shouldn't just get whatever they want in the law." We'll have consumer groups. We'll have allied professionals. We'll have third party payors. We'll have hospitals. We'll have government. We'll have a lot of people saying, "We want involvement in this." That makes it very, very crucial. Very important. So all of these factors cause some people to say, "Let's do this next year when it's going to expire."

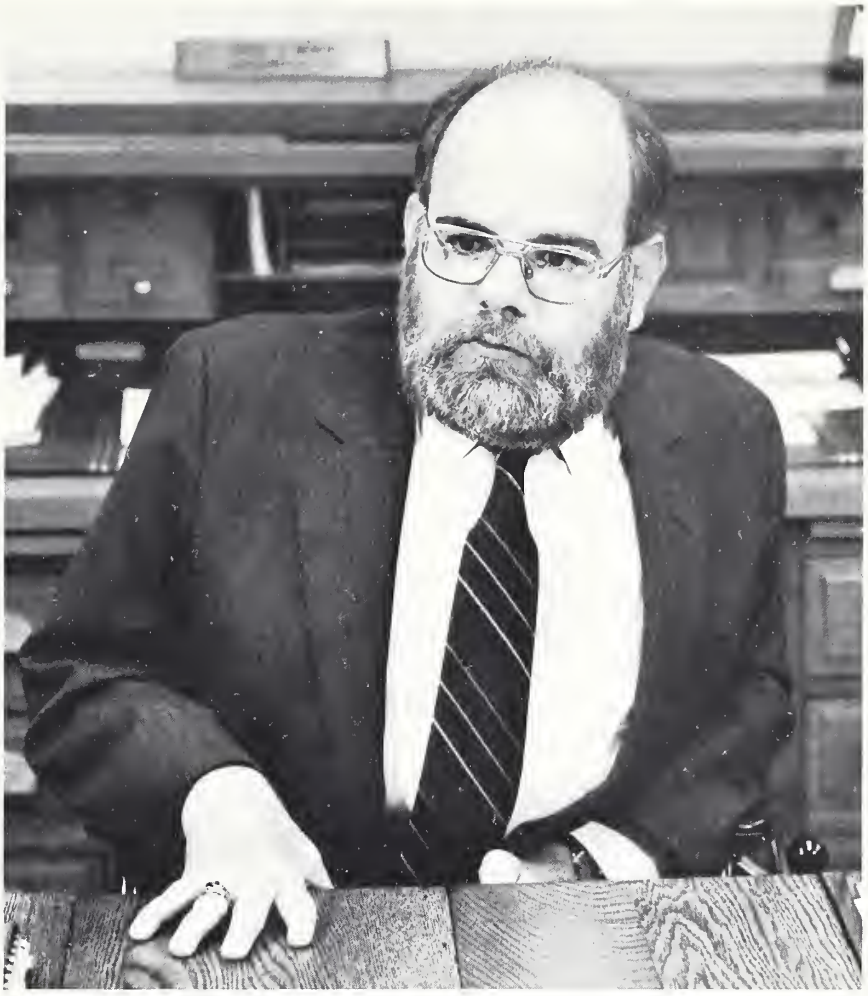
IMJ: *Do all the health profession bills sunset at the same time?*

Saul Morse: Most of them. Nurses do, physicians, psychologists, social workers and a number of others.

IMJ: *In the view of the legislators, do you think that physicians, nurses and other health professionals are considered to be members of one unit whose duties should be defined in tandem?*

Saul Morse: To some degree, there were people saying, "Look, if we've got health care coming up in '87, let's look at it as a package. We hear so much about the health care delivery system. If it is a system, let's look at it all together."

IMJ: *What's the worst picture scenario? What do physicians have to lose?*



We're talking about gut issues here—the license to practice and what it means.

Saul Morse: If I were a physician trying to define the worst case scenario, I would consider a situation in which there were five or six other professions that could do the same thing that I do. I would look at a situation in which my entire method of rendering care and running my office was subject to specific controls. I would look at a situation in which I could choose to participate in a peer review committee, but it would all be public. I would look at a situation in which third party reimbursement would be cut. And I would look at a situation in which I could pay three and four times as much per year for my license.

IMJ: *What are some of the peripheral arguments which might cloud the issues relating to discipline?*

Saul Morse: People will say it doesn't matter what we pass in the law on discipline as long as other physicians have to turn in or testify against their fellow physicians. Some will claim that the Medical Disciplinary Board can't be impartial because its composition is physician-dominant and that's the fox guarding the chicken coop. They'll say all those things.

But those who oppose the disciplinary reforms won't have a response

to the question of how anyone other than another physician can review a physician's professional ability. Who else is qualified? Who else knows medicine?

subscribes to an oath to help and care for people, its members assume some responsibility for the basic quality of that care. Permitting people who do not provide the best quality care to remain in the system is a contradiction which cannot be explained away.



The issue of access is not just getting in the door, but getting out the door at least as well off, if not better off, than you were before.

IMJ: *Sunset review has been referred to as the proverbial can of worms.*

Saul Morse: Absolutely. The entire concept of medical practice will be re-examined. And there are people—legislators included—who are bitter about the success that we've had. Really bitter about the malpractice reforms. Some people out there—maybe even among the legislative leadership—thought they could stop us. Didn't agree with us. Were more aligned with other groups. And we won the day. The members ought to realize that some people are going to say, "You guys have been too successful. We're going to show you."

IMJ: *This is a complex kind of issue and it's not very sexy compared to the first malpractice battle. What should our members be prepared to argue when they meet with their legislators?*

Saul Morse: There are a number of things they should be saying and evaluating. It strikes me that any system which does not quickly deal with physicians who are negligent, not practicing good care, or impaired, is a system which is bad for everyone—physicians included. While licensure, and therefore discipline, is primarily the responsibility of the state, and not the profession, it is in the physicians' own best interest to make sure that their peers render the best care possible. Historically, physicians have taken the lead in encouraging appropriate laws for that purpose. They define the environment in which everybody functions. When a profession

You have to say to legislators, "On the whole, look at the care that is rendered. Look at what physicians do. Look at what medicine has come to be. Can you honestly say that you and your constituents would receive better care if we changed the methods and the rules by which it's rendered?" I don't think any legislator can honestly say that. That's the key. If it ain't broke, don't fix it. I think that's important. And I think it's important to ask a legislator, "Who else could do as good a job of taking care of the whole person as physicians do?"

IMJ: *What if he says, "Yes, but we want access. And the best way to get more access for more people is to save money by having more services delegated to persons with less expertise?"*

Saul Morse: Let's say you wanted to cross a river. And access to crossing the river meant having boats. Having more boats is not a viable option if a couple of them sink. The issue of access is not just getting in the door, but getting out the door at least as well off, if not better off, than you were before.

Access is a vital question. It's a valid question. Access may not be helped by things like PPOs, for example, which cut down on the number of available providers. You can't go to any physician. You can't go to any hospital. Not in the name of quality of care, but in the name of cost. That doesn't mean that the available options aren't good ones. The legislature voted for that system. Has it improved access? Access is provided by improving the status quo. It's not provided by opening it up to anyone and everyone regardless of qualifications.

IMJ: *Access and quality have to coincide.*

Saul Morse: They're the same issue. They really are tied together. There's just no way that you can separate them.

We have a system of limitations. There are problems; there always will be. It's not a perfect world. Look at what we have now and tell me who else can do it better.

I would ask the legislators, "What specific things aren't physicians doing? What specific things could some other profession do better than physicians?" I don't know the answer to that question. But we have to ask. It's a risk. When you ask any question, there's a risk. But we have to know what they think.

In 1987, we're going to find out. ◀

ABSTRACTS OF ACTIONS

September 20, 1986 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

BUDGET

The 1987 ISMS budget was presented by the Executive Committee. It maintains a level of expense necessary to conduct all current membership services with additional services in expanded research capabilities for health care finance and a readership survey for the *Illinois Medical Journal.* The Finance Committee had prepared the budget in keeping with the level of membership dues required. The 1987 budget calls for a deficit close to $500,000. The House of Delegates had authorized a dues increase of up to $20 for 1987, if necessary. Implementing this $20 increase would reduce by nearly $250,000 the operating deficit.

The Board approved: (1) That full membership dues for 1987 be established at $273 per year, implementing the dues increase of $20 authorized by the House of Delegates in April, 1986; and (2) A 1987 budget reflecting income of $4,144,222 and expenses of $4,439,952.

PROFESSIONAL LIABILITY INITIATIVE II

In order to have legislative reforms enacted, the Board approved the following elements of PLI II: (1) Continued development of coalitions to gain support within the health care community for medical malpractice reforms, and continued communication with other groups interested in tort reform; (2) Development of legislation which would provide a $250,000 cap on noneconomic loss, and provide that the statute of limitations for minors commence at age six; (3) A tentative budget of $406,000 for activities that would include a public awareness campaign, reactivation of Action Teams, and public and member education; and (4) The theme "Malpractice: Nobody Wins—Everybody Pays," be retained.

MEDICAL PRACTICE ACT

The Medical Practice Act will be subject to legislative sunset review which could result in either revision of the current Act, reenactment of the current Act, or adoption of an entirely new Act, on or before December 31, 1987. Various approaches which must be considered for monitoring the sunset process have been discussed. Concerns exist as to challenges which may be brought to impinge upon the practice of medicine and/or restrict the ability of physicians to practice. Both the Medical Examining Committee and the Medical Disciplinary Board will be reviewing the Act to make suggestions for change. ISMS previously supported modifications of the Medical Practice Act pertaining to discipline and it is anticipated that proposals from the last session will become the starting point for the legislature. Additionally, various pending lawsuits pertaining to the practice of naprapathy, psychology and acupuncture may impact on those licensed under this Act.

Due to the fact that this sunset will involve a major society initiative, with very serious considerations, the Board agreed to establish an ad hoc committee to monitor the sunset review of the Medical Practice Act.

CHILD ABUSE EDUCATION PROGRAM

The Board authorized development of a program on child abuse education over the next six months to be funded by a $60,000 grant from the Department of Children and Family Services. Existing staff resources are sufficient to absorb this activity. ISMS will develop seminars and educational materials for hospital medical staffs and county medical societies. The purpose of this program is to improve the ability to recognize child abuse and to assist in assuring medical support for such children.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

This is the fourth year for this Task Force activity, which granted loans of $50,000 the first year, $75,000 the second year and $100,000 the third year. The Board authorized that: (1) $125,000 be released from the Illinois State Medical Society student loan fund account for the purpose of providing student loans to eight Illinois medical schools for academic year 1986-87 in the following increments: University of Chicago Pritzker School of Medicine, $16,550; Loyola University Stritch School of Medicine, $13,212; Rush Medical College, $14,100; Chicago College of Osteopathic Medicine, $13,325; Northwestern University Medical School, $22,275; University of Illinois, $14,888; Southern Illinois University, $7,625; Chicago Medical School, $23,025; and (2) Interest rates be set for the above loans at 5.5% to allow for basic administrative costs of the program.

POLICY COMMITTEE

Upon recommendation of the Policy Committee, based upon actions taken by the House of Delegates at

the 1986 annual meeting, the Board approved the following policy statements for inclusion in the Policy Manual:

New Policies

- Risk Management
- Peer Review

Amended Policies

- Mental Health
- Freedom of Choice
- Physician Recruitment Service
- Public Aid
- Relationship with Third Party Payors
- Continuing Education
- Nurses—Shortage
- Health Insurance, Governmental Programs

In addition, upon recommendation of the Policy Committee, the Board approved the following:

Existing HOD Actions

- Retain Policy Manual Statements on Public Statements; Public Statements, Endorsements; Legislation; Reimbursement for Treating Medicaid Patients.
- Delete Official ISMS Action statements on: Direct Billing (Third Party Payors); Impact of Medicaid Changes on Residency Programs (Medicaid); Health Care Delivery Programs (Foundations for Medical Care); Public Health Director (Public Health/Safety).

The Board also agreed to develop a resolution calling for the Director of IDPH to be a physician.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Orthoclone OKT 3, Injection 1mg/ml, Muromonab-CD3; NIX, Creme Rinse 1%, Permethrin; Roferon-A, Injection 3 million IU/ml, Interferon alfa-2A, Recombinant; Intron A, Injection 3 million IU/vial, Interferon alfa-2B, Recombinant; Dexamethasone Intensol, Oral Sol. 0.5mg/0.5ml, Dexamethasone; Dexamethasone, Oral Sol. 0.5mg/0.5ml, Dexamethasone; Prednisone Intensol, Oral Sol. 0.5mg/ml, Prednisone; Prednisone, Oral Sol. 5mg/5ml; Roxicodone, Oral Sol. 5mg/5ml, 5mg tab., Oxyodone HCL; Neptazane, 50mg tab., Methazolamide.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Citracal, 200mg, Calcium Tablets, Calcium Citrate; Gastrolyte, Oral Electrolyte Concentrate, Dextrose 400mg, Sodium Chloride 700mg, Sodium Citrate 580mg, Potassium Chloride 300mg, Colloidal Silica, Calcium Silicate, Disodium Inosinate, Disodium Guanylate, Quinine Hydrochloride, C Scorbitol Flavoring; Bumex, Injection/Tablets, Bumetanide.

The Board further recommended that IDPA delete Dexamethasone Elixir from its Drug Manual.

In addition, the Board reconsidered the drug products Haldol Decanoate and Nitrolingual Spray and recommended that IDPA: (1) Include Haldol Decanoate in its Drug Manual for non-group care patients; (2) Make Haldol Decanoate available to residents of group care settings on a prior approval basis; and (3) Include nitrolingual spray in its Drug Manual.

AIDS

The Board agreed to adopt the following positions on AIDS issues:

Look-Back Campaigns

1. ISMS should support the concept of "look-back" as a means of protecting patients and reducing the possible spread of disease.
2. When a physician is notified that one of his/her patients has received blood from a donor who is now known to be Western Blot positive, the doctor should:
   a. promptly notify the patient of the need to visit the office to discuss a medical condition;
   b. advise the patient in a confidential and personal fashion of the situation;
   c. offer to perform an HTLV-III antibody test; and
   d. be prepared to provide the patient with social-psychiatric support and referral to an infectious disease specialist.
3. In conjunction with their hospitals and the local blood centers, medical staffs should develop policies and procedures for determining which physician should be contacted about a patient who received such blood and who should be responsible for notifying the patient.
4. Information related to Western Blot positive donors, and patients who received blood from such donors, should be strictly confidential and maintained as such by all individuals privileged to have such information.

AIDS and Antibody Testing

1. Physicians should provide competent and humane care to all patients, including those with critically ill conditions such as AIDS and AIDS-related conditions.
2. Upon request, ISMS should provide information to its members on the many issues and developments related to AIDS, including information on resources and specialists available to AIDS patients, so the physician can educate himself and others about the disease and the HTLV-III virus, and the limited mechanism by which the virus is or can be transmitted.
3. Testing for the HTLV-III antibody should be used only in situations which benefit individual patients and the public health.
4. Counseling and educational efforts, rather than policies promoting physicial restriction and isolation, are appropriate primary methods for controlling the spread of AIDS and HTLV-III infections, until further information suggests otherwise.
5. The privacy of patients infected with the HTLV-III virus should be protected.
6. Physicians should incorporate into their practices standard procedures for taking complete sexual and lifestyle histories of their patients and should assume responsibility for educating their high-risk

patients about the need to modify behavior which places the patient at risk for HTLV-III infection.

7. ISMS should support continued research into the causes, prevention and treatment of AIDS and AIDS-related conditions.

OTHER ACTIONS

In addressing various other issues, the Board:

- Accepted the Financial Statements for the period ended June 30, 1986; August 29, 1986, IMPAC Collection Data; August 31, 1986, Dues Payment Report; and Requests for Changes in Membership Status.
- Reported that the Executive Committee intends to defer consideration of any 1988 membership dues level requirements until the January, 1987 Board of Trustees meeting, pending a review and recommendation by the Finance Committee based on 1986 year-end operating results. The Finance and Medical Benevolence Committee intends to explore sources of non-dues revenue.
- Ratified approval of up to $75,000 for remodeling and repair of the Springfield office building.
- Agreed that no contribution to support the implementation of the AMA Health Policy Agenda be made until ISMS has had opportunity to review and act upon final proposals, after which a decision will be made by the Board as to any contribution.
- Approved an expenditure of up to $2000 in the 1987 budget for election activities related to the National Governing Council of the AMA Hospital Medical Staff Section.
- Declined endorsement of an IDPA/DCFS proposed project concerning approximately 3000 wards of the Department of Children and Family Services who would be enrolled in an HMO for the full range of medical and health care services.
- Declined endorsement of an IDPA "Healthy Kids" project to publicize the Medichek program.
- Authorized the Chairman of the Board of Trustees to provide appropriate assistance to AMA's attempts to positively impact the Medicare program with the Congress.
- Agreed that no changes would be effected in the 1987 *IMJ* subscription rates.
- Declined Crescent Counties Foundation for Medical Care's invitation to participate in a joint committee to discuss mutual issues concerning HCFA's mandated review policies at this time, and agreed to continue working through the existing structure to discuss issues.
- Approved the "Continuing Medical Education Mission Statement," to be included in the ISMS application for accreditation.
- Directed that the policy statement entitled "Medical Testimony, Expert Witnesses" be amended as follows and that a resolution be developed for the 1987 House of Delegates:

  "An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, relevant personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and who was currently active in the practice of the medical subject under discussion at the time the incident occurred."
- Referred back to the Council on Medical Services a recommendation that ISMS adopt positions regarding situations where a physician happens upon a scene of a medical emergency and the physician desires to take complete medical and legal responsibility for the patient.
- Approved a study of young physicians by the Council on Public Relations and Membership Services. Res. 30 (A-86) which was referred to the Board of Trustees, asked that an Ad Hoc Committee on Young Physicians be established.
- Approved: (1) Revisions of the "Procedure Manual for Accreditation of Sponsors of Continuing Medical Education" and "Procedures for Reconsideration and Appeal of Adverse Accreditation Decisions;" and (2) Inclusion of an ISMS educational consultant/staff on accreditation site surveys to serve in an advisory and non-voting role.
- Approved conducting a student loan fund raffle at the 1987 Annual Meeting.

PROGRAMS

The Board:

- Approved an All Member Conference agenda and a registration fee of $50.
- Approved a pilot seminar program, in conjunction with a county medical society, that would address the needs of physicians in the business side of medical practice.
- Agreed to serve as host for a multistate conference of medical society student loan programs, with costs supported by outside contributions and registrant fees.

UNFINISHED BUSINESS REPORTS

The Board approved the following Unfinished Business Reports for the 1987 Annual Meeting:

- Addressing the Health Insurance Needs of the Short-Term Unemployed and Those Persons "Medically Uninsurable" (Res. 29 A-86)
- Policy Statement on Governmentally-Supported Health Facilities (Res. 8 A-86)
- Application of Input-Output Economics to Health Care (Res. 14 A-86)
- Honesty in Offering an HMO (Res. 16 A-86)
- Medical Staff Bylaws for Outpatient Surgical Centers (Res. 36 A-86)
- Corporal Punishment in Illinois Schools (Res. 1 A-86)
- Reduced Dues for Young Physicians (Res. 18 A-86)

NOMINATIONS AND APPOINTMENTS

Various nominations and appointments were approved or ratified by the Board, as follows:

- Ratified appointment of Drs. Alfred J. Clementi,

chairman, Jere E. Freidheim, Allan L. Goslin, Lawrence L. Hirsch, Harold L. Jensen, Alfred J. Kiessel, Morgan M. Meyer, Pedro A. Poma, Arthur R. Traugott and Charles K. Wells, to an ad hoc committee to monitor the sunset review of the Medical Practice Act through 1987.

- Appointed Dr. Alan M. Roman, Blue Island, delegate, and Dr. Michael Davidson, Chicago, alternate delegate, to the December, 1986, meeting of the AMA Young Physicians Section.
- Ratified appointment of the following physicians to serve on the Planning and Priorities Committee: Allan L. Goslin, chairman, Rafael C. Campanini, Raymond E. Hoffmann, Harold L. Jensen, John W. Mason, Ronald G. Welch and Fred Z. White.
- Ratified nomination of Dr. Boyd E. McCracken, Greenville, to serve on a Blue Ribbon Commission of the State Board of Education.
- Appointed Dr.Richard Quinones as delegate on the ISMS Delegation to the AMA to fill the unexpired term of Dr. Michael Nieder.
- Nominated Drs. Eli Borkon, Carbondale, and Charles Wells, Mount Vernon, for reappointment to the Medical Disciplinary Board.
- Nominated Dr. Biswamay Ray, Oak Brook, to serve on the Department of Registration and Education's Medical Disciplinary Board to complete the term of Dr. Hugo Velarde, Chicago, who resigned.
- Ratified nomination of Dr. Peter J. Soto, Belleville, to the IDPH Clinical Laboratory and Blood Bank Committee.
- Nominated Dr. Darryl E. Statzer, Decatur, for appointment to the IDPH Emergency Medical Services Council, and Dr. Ron W. Lee, Chicago, for reappointment.
- Appointed Dr. Morgan M. Meyer to the Task Force on Financial Aid to Medical Students.
- Ratified appointment of Dr. Robert M. Jarrett, Rockford, to the Sports Medicine Committee.

PHYSICIAN CONTRACTING/NEGOTIATING

The Board was informed that the Executive Committee has authorized legal counsel to develop an in-depth proposal for further consideration of the alternatives under an IPA. Additionally, ISMS will continue to provide contract review service. As included in the 1987 budget, the Executive Committee reviewed a proposal to improve this membership benefit and to enhance this activity by distribution of a brochure, development of regular *IMJ* articles, and other presentation pieces.

INFORMATIONAL REPORTS

Informational reports were presented by the Council on Governmental Affairs, Committee for the Impaired Physician, ISMIS, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section, IMPAC, Trustees, Speaker and AMA Delegation Chairman.

NEXT MEETING

The next Board of Trustees meeting was set for November 7, 1986, at the Drake Oakbrook. ◀

OBITUARIES

***Acharya, Sumantrai D.,** Northlake, died August 18, 1986 at the age of 46. Dr. Acharya was a 1966 graduate of the University of Bombay Medical College, India.

****Andrews, Albert H., Jr.,** Chicago, died September 26, 1986 at the age of 79. Dr. Andrews was a 1933 graduate of Northwestern University Medical School, Chicago.

****Arnal, Paul J.,** River Forest, died September 23, 1986 at the age of 83. Dr. Arnal was a 1931 graduate of Northwestern University Medical School, Chicago.

****Benton, Eric C.,** Chicago, died September 9, 1986 at the age of 87. Dr. Benton was a 1925 graduate of the Medizinische Fakultat der Martin-Luther Universitat, Halle, Germany.

Cannon, Paul R., Yorkville, died September 7, 1986 at the age of 94. Dr. Cannon was a 1926 graduate of Rush Medical College, Chicago.

****Claycomb, Arnold H.,** Pekin, died August 31, 1986 at the age of 84. Dr. Claycomb was a 1934 graduate of Northwestern University Medical School, Chicago.

Gardner, Leon P., Chicago, died September 10, 1986 at the age of 73. Dr. Gardner was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

***Johnson, Chester T.,** Decatur, died August 27, 1986 at the age of 70. Dr. Johnson was a 1940 graduate of Rush Medical College, Chicago.

****Levine, Albert J.,** Skokie, died September 25, 1986 at the age of 77. Dr. Levine was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

****Malstrom, Bernard E.,** Galesburg, died August 19, 1986 at the age of 77. Dr. Malstrom was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

***Shulruff, Joseph T.,** Chicago, died September 12, 1986 at the age of 71. Dr. Shulruff was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

***Talso, Peter J.,** Chicago, died August 16, 1986 at the age of 64. Dr. Talso was a 1945 graduate of the Wayne State University School of Medicine, Detroit.

****Weber, Leonard F.,** Chicago, died May 29, 1986 at the age of 90. Dr. Weber was a 1922 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club* ◀

The AMA-ERF Working for You

By Norma Kiessel (Mrs. Alfred), ISMSA AMA-ERF Chairman

The American Medical Association Education and Research Foundation (AMA-ERF) consistently supports quality medical education in the United States by contributing more than $1.75 million yearly as a continuing commitment to medical excellence. This is done through the extraordinary fundraising efforts of the auxiliary and through the generous contributions of medical families. The AMA-ERF national, state and county auxiliary chairmen form a network of hardworking, dedicated and inventive auxilians.

Last year, Illinois was fourth in the nation for total contributions. Twenty county auxiliaries took part in one or more fundraising activities. Our total auxiliary contribution was $83,459.48. Of this, $26,480.48 was raised by our counties through sharing cards, Christmas card sales, boutiques, memorials, special fundraisers and personal contributions. Each reflects the grassroots effort for the AMA-ERF. Direct auxiliary contributions were $56,979.00; physician contributions totalled $35,500. Combined, a grand total of $118,959.48 was contributed by Illinois auxilians and physicians. As AMA-ERF state chairman for 1985-86 and again in 1986-87, I feel privileged to be able to work with these energetic and dedicated national, state and county auxilians.

With the numerous changes that are taking place in the funding of medical schools, loans available to medical students, medical assistance funds and medical research, we see greater and greater need for contributions. If medical excellence is to continue, we will be asked to give again and again in order to raise the funds needed to finance the future of medicine. If we, the medical families, do not contribute financially and personally to raise funds for AMA-ERF, its financial aid programs will be greatly diminished and medicine will surely suffer. AMA-ERF guarantees loans, and provides for the Medical Excellence Fund, the Medical Student Assistance Fund, and the Unrestricted Fund that benefit medical schools. This past year I visited all Illinois medical school deans and learned how important our AMA-ERF funding is to them, their medical schools, and the medical students. It's very much appreciated.

Our AMA-ERF county auxiliary chairmen are again asked to come up with effective and innovative ways to raise more and more of these funds. Our medical families are asked to contribute even more generously. It is a lot to ask each year when there are so many other commitments we must consider and evaluate. But what a wonderful opportunity this is to work with and for each other toward a common goal—a commitment to the future of medical excellence. Remember, all contributions to AMA-ERF are tax-exempt.

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

DECEMBER

Obstetrics/Gynecology

Advanced Colposcopy and Laser Surgery
For: Gynecologists. Conference and workshop, December 4-6, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $325. **Reg. Limit:** 110. **Credit:** Category 1: 16 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Problem Solving in Gynecologic Endocrinology and Infertility
For: Obstetricians and gynecologists. Course, December 12-13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolaryngologists. Laser workshop, December 8-9, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Neurology

Neurology for the Non-Neurologist
For: Family practitioners, internists, and psychiatrists. Lectures/workshops, December 10-12, Chicago. **Sponsor:** Rush University, Rush Presbyterian-St. Luke's Med. Center, University Office of CME, 600 S. Paulina, Chicago, IL 60612. **Fee:** To be determined. **Reg. Limit:** none. **Credit:** Category 1: 20 hours; AAFP elective: Credit applied for. **Contact:** Barbara Trejo. **Phone:** (312) 942-7095.

Surgery

Symposium on Vascular Emergencies
For: Surgeons. Symposium, December 11-13, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $450. **Reg. Limit:** 500. **Credit:** Category 1: 16.5 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Family Medicine

Low Back & Sciatic Pain: Evaluation & Treatment
For: Physicians. Seminar, December 12-13, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. Limit:** 150. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; and AOA: 12 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Cardiovascular Medicine Today: Theory and Practice
For: Family practitioners, general practitioners and cardiologists. Conference, December 3, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 4½ hours; AAFP Prescribed: 4½ hours; and AOA: 4½ hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Cardiology

Cardiovascular Practice 1986-87: A Summary for the Current Physician
For: Physicians and other health professionals. Conference, December 5, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705 and Cardiology Section, Department of Medicine, School of Medicine, University of Wisconsin-Madison. **Fee:** To be announced. **Registration Limit:** None. **Credit:** Category 1: 7 hours; AAFP Prescribed: credit applied for; AOA Category 2-D and University of Wisconsin CEUs: 7 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Ventricular Arrhythmias—Update 1987
For: Cardiologists. Symposium, December 20, 8:30 a.m.-1:30 p.m., Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 1753 W. Congress Parkway, Chicago, IL 60612. **Fee:** $35. **Reg. Limit:** 250. **Credit:** Category 1: 3 hours. **Contact:** Vicky O'Sullivan, University Office of CME, 600 S. Paulina, Chicago, IL 60612.

Pathology

Risk Management and Quality Assurance for the Pathologist
For: Pathologists. Lecture, December 8, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Geriatrics

Fifth Annual Symposium in Geriatric Medicine
For: Family practitioners, general practitioners and internists. Conference, December 10, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** $65. **Reg. Limit:** None. **Credit:** Category 1: 5 hours; AAFP Prescribed: 5 hours; and AOA: 5 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

January

Surgery

Specialty Review in Thoracic Surgery
For: Thoracic surgeons, general surgeons and cardiovascular surgeons. Lecture, January 5-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $705. **Reg. Limit:** None. **Credit:** Category 1: 47 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Pathology

Physicians' Office Testing
For: Pathologists and clinical chemists. Lecture, January 12, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Family Medicine

Ventricular Arrhythmia Update
For: Family and general practitioners, internists, and cardiologists. Conference, January 17, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; and AOA: 6 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

February

Pathology

Overview of Chicago Blood Banking; Controversies in Blood Banking; Direct Donation
For: Pathologists. Lecture, February 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

EKG

(Continued from page 306)

Answers: 1. C, D 2. E

The twelve lead ECG shows a heart rate of 150 beats per minute. No sinus or ectopic P waves are seen, and the QRS duration is prolonged with an RsR^1 pattern in lead V_1 compatible with complete right bundle branch block. The absence of P waves and the irregularly irregular cycle lengths are caused by atrial fibrillation.

This patient developed atrial fibrillation with complete right bundle branch block and a new right-sided pleural effusion on his fifth postoperative day.

An exploratory laparotomy was needed for an admitting diagnosis. Carcinoma of the stomach was found. Pathology revealed the carcinoma to be an infiltrating, poorly-differentiated adenocarcinoma which almost extended to the margin of the dissection. A total gastrectomy with esophagojejunostomy was performed, as well as a feeding jejunostomy.

All of the possibilities in question two were considered on postoperative day five. There was no ECG evidence of myocardial infarction. His anticoagulation for the aortic valve prosthesis was held in the perioperative period. Postoperative bleeding could not be demonstrated. The sudden onset of atrial fibrillation, complete right bundle branch block, a new pleural effusion, and dyspnea strongly suggested a pulmonary embolism. Arterial blood gases showed a respiratory alkalosis. The ventilation perfusion (V/Q) scan confirmed the diagnosis of pulmonary embolism. The exact mechanism for the atrial fibrillation was unclear since the pulmonary embolism was not massive and did not cause right heart failure.

An increased dose of digoxin and heparin anticoagulation were administered. The patient converted to normal sinus rhythm the next day and had an uneventful postoperative course. ◀

U.S. Postal Service

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Illinois State Medical Society; Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

EDITOR *(Name and Complete Mailing Address)*

None

MANAGING EDITOR *(Name and Complete Mailing Address)*

Mariann M. Stephens; Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)*

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The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

[X] (1) HAS NOT CHANGED DURING PRECEDING 12 MONTHS
[ ] (2) HAS CHANGED DURING PRECEDING 12 MONTHS

(If changed, publisher must submit explanation of change with this statement.)

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B. PAID AND/OR REQUESTED CIRCULATION 1. Sales through dealers and carriers, street vendors and counter sales	---	---
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11. I certify that the statements made by me above are correct and complete

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Mariann M. Stephens, Managing Editor

PS Form 3526, Dec. 1985 *(See instruction on reverse)*

ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Impaired Physician Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

The Physician Help Line is open 24 hours, 7 days a week. Calls will be answered as soon as possible, and information is shared only with the physicians helping the person who calls.

One Student's Perspective

The Medical Assisting Profession

By Charlene Endre, Triton College/River Grove

Medical assisting is a profession which contributes greatly to the physician's practice. As a sophomore in Triton College's medical assisting program, I am working toward an associate of applied science degree while obtaining practical experience through related employment.

The medical field can provide an exciting career filled with a never-ending assortment of challenges and diverse tasks.

Classroom skills fall into clinical and administrative areas. They include instruction in vital signs, electrocardiography, injections, venipuncture, dressing and bandaging, sterilization, audiometry, spirometry, draping and positioning, office surgery procedure, medical ethics and law, insurance forms, computer literacy and office management.

These qualifications would seem to indicate that physicians who hire a medical assistant for the office gain a real asset.

Experience is a great asset. At Triton College, and other accredited programs, the externships provide experience. Our externship takes place in the student's last semester, and lasts 16 weeks. Students gain hands-on experience and confidence by using skills that have been practiced in the classroom. The externship affords a balanced clinical and administrative experience.

At the conclusion of the accredited program, a nationally recognized certification exam is offered. This certification exam is optional, but those students who pass can then be called Certified Medical Assistants (CMA). This will assure physicians of employing top quality assistants.

A medical assistant's starting salary should be based upon educational background, certification status, and/or experience. Physicians in need of salary information for medical assistants should contact area program coordinators who frequently survey graduates to determine average starting salaries.

Rapid expansion in the medical field and growing liability problems support the proposal that physicians consider employing a professional medical assistant when in need of a skilled addition to the office.

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 E. Jackson St., Bloomington 61701; Robin Bluestein, CMA-C, co-chairman, Public Relations Committee, 2247 W. Estes, #2, Chicago 60645, or Catherine M. Hill, CMA, co-chairman, Public Relations Committee, 900 S. Plum Grove Road, Palatine 60067. ◀

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies.

From the Department of Registration and Education (DRE)

Medical Disciplinary Orders

- *Edward G. Fortier* (Lic. #036-629037 & 003-036-629037)
  Effective August 12, 1986, Dr. Fortier's medical and controlled substance licenses were revoked for a period of at least five years.
- *Marlow Harston* (Lic. #036-028005)
  Effective August 19, 1986, Dr. Harston's medical license was indefinitely suspended.
- *Gordon Messmore* (Lic. #036-038473 & 003-036-038473-1)
  Effective August 27, 1986, Dr. Messmore's controlled substance license was placed on a one year probation.
- *Lowell F. Millburn, Jr.* (Lic. #036-039817 & 003-036-039817)
  Effective August 22, 1986, Dr. Millburn's medical and controlled substance licenses were indefinitely suspended for not less than two years.
- *Mark Mench* (Lic. #036-061486)
  Effective September 4, 1986, Dr. Mench's medical license was suspended pending his meeting certain conditions.
- *Illur G. Sathy* (Lic. #036-045627)
  Effective August 27, 1986, Dr. Sathy's medical license was suspended for a one year period and his controlled substance license was revoked.
- *Milton C. Schell* (Lic. #036-019567)
  Effective August 26, 1986, Dr. Schell's medical license was restored to unencumbered good standing.
- *Edir Siqueira* (Lic. #036-037951)
  Effective August 19, 1986, Dr. Siqueira's medical license was indefinitely suspended.
- *Gary Eugene Stanford* (Lic. #036-057916)
  Effective August 19, 1986, Dr. Stanford's medical license was suspended indefinitely.
- *Jerry L. Thurman* (Lic. #036-056819)
  Effective September 4, 1986, the DRE restored Dr. Thurman's license to active status retroactive to June 1, 1984, and terminated his probationary status.

(Source: Orders received from the Director of DRE)◀

Position Notice

Assistant Professor of Medicine
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at Urbana-Champaign

Permanent, full-time tenure-track position. Supervise and evaluate pathophysiology instruction for second-year medical students; participate in active clinical teaching of students and residents; carry out independent research; conduct clinical practice in endocrinology and metabolism. M.D.; licensed or eligible for licensure in Illinois; board certification in medicine required. Eligibility or certification in medical subspecialty desirable. Teaching experience and experience in curriculum design and administration preferred. Position available August 21, 1987. For fullest consideration, submit letter of application, curriculum vitae, and names, addresses, and telephone numbers of six references by December 5, 1986 to:

Ralph A. Nelson, M.D., Head
Department of Internal Medicine
University of Illinois
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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MOUNT CARMEL:
Orthopedic Surgeon, Pediatrician and Family Practitioner—Population 10,000. 64 bed JCAH accredited general hospital, HCA managed, newly built in 1983 replacing a well-established older hospital. Good secondary and high-school and junior college. First year guarantee and other excellent fringe benefits, a lovely river city with several large thriving industries. Any cultural or recreational benefits not provided here are available in nearby large city. Contact: William S. Vokonas, Administrator; Wabash General Hospital, 1418 College Drive, Mt. Carmel, 62863, or phone (618) 262-8621, extension 300. (1)

OAK PARK
Several excellent opportunities immediately available to replace retiring family practice physicians in western suburbs of Chicago. Hospital will provide generous income guarantee, and practice-building and management expertise. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Full time faculty position. Assistant Director of Family Practice center. Responsibilities include teaching in an outpatient setting, monitoring residents, and teaching procedural skills. Some direct patient care. Excellent compensation and benefits. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Two immediate care centers in near west suburbs of Chicago have full and part-time positions immediately available. Opportunity to develop private practice if desired. Hospital will support practice. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Freestanding occupational health centers associated with prestigious community hospital in western suburbs of Chicago have immediate openings for both full and part-time physicians. Excellent compensation. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

OAK PARK:
Growing, 374-bed community hospital in near-west suburb of Chicago seeks board eligible or board certified pediatricians to associate with existing practices. Salary to start, working into partnership. Contact Cheryl Newman, West Suburban Hospital, Erie at Austin, Oak Park 60302. (312) 383-6200. (12)

PEKIN:
Opened new 20-office multi-specialty physician's medical center attached to Pekin Memorial Hospital, a 202-bed progressive community hospital. Competitive income guarantee and relocation allowance available. Contact: Ruth Campbell, Court and 14th Streets, Pekin, 61554. (1)

PITTSFIELD:
Illini Community Hospital. Practice opportunities for FP, OB/GYN, Internist and Pediatrician; solo or partnership. Office space and financial assistance available. Service area 25,000. Excellent outdoor recreation. Close to St. Louis and Springfield. Good school systems, including colleges and universities. Contact: Kathleen Wegener, 640 W. Washington, Pittsfield, 62363. (217) 285-2113. (2)

SYCAMORE:
Internist with subspecialty interest in rheumatology to join a well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, 60178. (1)

VIEWBOX

(Continued from page 303)

Diagnosis: Primary Thymic Carcinoid Tumor

All of the choices given can cause anterior mediastinal masses. Only thymic carcinoid produces ectopic ACTH and is associated with Cushing's syndrome.[1-4]

Ectopic ACTH production is responsible for Cushing's syndrome in about 15% of patients. (Table 1) The most common neoplasms producing ectopic ACTH are listed in Table 2. In general, carcinoid tumors in organs derived from foregut may be associated with Cushing's syndrome. These include tumors of the lung, thymus, stomach, pancreas, and duodenum. Midgut carcinoids are more often associated with the carcinoid syndrome. Carcinoids of the hindgut are not hormonally active.[4]

Primary carcinoid tumors of the thymus are not as well recognized as those involving the gastrointestinal tract. Primary thymic carcinoid was first described in 1972, when the tumor was separated from the more common thymoma.[1] It is postulated that these rare neoplasms are derived from the neural crest during embryogenesis and have their origins in the foregut. Stemming from neuroendocrine cells found in the thymus, these tumors often display hormonal activity.[2-4] They are aggressive, and may follow a malignant course.

Table 1
Cushing's syndrome, etiology

ACTH dependent	
Pituitary adenomas	70%
Ectopic ACTH production	15%
ACTH independent	
Adrenal adenoma	8%
Adrenal carcinoma	7%

Table 2
Ectopic ACTH production, neoplasms[11]

- ☐ Small cell bronchogenic carcinoma
- ☐ Thymic carcinoid tumor
- ☐ Pancreatic islet cell carcinoma
- ☐ Carcinoid tumors: lung, intestine, pancreas, ovary
- ☐ Medullary thyroid carcinoma
- ☐ Pheochromocytoma
- ☐ Other

  Melanoma, colon adenocarcinoma, ovarian arrhenoblastoma, parathyroid carcinoma, nephroblastoma

Clinical

Thymic carcinoid tumors are often clinically silent and are usually discovered accidentally.[5] They have been reported in individuals ranging in age from 9-87 years, but occur most often in middle-aged men.[6] Symptoms may be caused by local mediastinal invasion[7] and the superior vena cava syndrome has occurred.[2,3] Patients may also present with endocrinopathy, usually Cushing's syndrome.[2-5] These tumors are not associated with the carcinoid syndrome.

Thymic carcinoids are hormonally active in up to 50% of cases;[3] one-third of these neoplasms are associated with paraneoplastic syndromes. This usually takes the form of ectopic adrenocorticotrophic hormone production, causing Cushing's syndrome. However, hyperparathyroidism and a possible case of inappropriate antidiuretic hormone secretion have been reported.[2,3] Multiple endocrine neoplasia syndrome Type I is reported to be associated with thymic carcinoid in 19% of cases.[2-5] These have all been in males. Absence of the carcinoid syndrome is probably due to the deficiency of aromatic amino acid decarboxylase in these tumors.[8] This enzyme converts 5-hydroxytryptophan into serotonin, which produces the signs and symptoms characterizing the syndrome.

Radiology

A mediastinal mass associated with bilateral adrenal hyperplasia and signs of Cushing's syndrome suggests the diagnosis of thymic carcinoid.[9,10] There also may be osteoblastic bone metastases. Radiographic detection of thymic carcinoid may be difficult, as these tumors are often not visible on routine PA and lateral chest films. Computed tomography, however, can detect the thymic mass.[4] The extent of tumor, invasion, and metastases can also be identified by CT.[9] A case of a calcified thymic carcinoid detected by CT has been reported.[4]

Diagnosis

Most thymomas have thick fibrous capsules, but thymic carcinoid tumors are not encapsulated. Thymoma may be confused with thymic carcinoid histologically, but the two can be distinguished by electron microscopy. Certain clinical characteristics also aid in their differentation. Thymoma is associated with myasthenia gravis, hypogammaglobulinemia, and aplastic anemia, and has a female predominance.[2,3] Thymic carcinoid is more common in men and is associated with Cushing's syndrome and multiple endocrine neoplasia. Thymomas show gross invasion of adjacent structures in about 10% of patients, while invasion has been observed in approximately 50% of thymic carcinoid cases.[3,5,7] Also, up to 30% of thymic carcinoids have distant metastases, often to bone and skin, while distant metastases are a rare feature of thymoma.[2,3]

Prognosis

While local invasion or distant metastases are common, the disease is often slowly progressive with prolonged survival. Wide excision with postoperative irradiation is the current mode of therapy. Recurrence has been observed up to ten years following resection.[3] ◀

References

1. Rosai, J., Higa, E.: "Mediastinal Endocrine Neoplasm of Probable Thymic Origin, Related to Carcinoid Tu-

mor," *Cancer* 29:1061-1074, 1972.
2. Birnberg, F.A., Webb, W.R., Selch, M.T., Gamsu, G., Goodman, P.C.: "Thymic Carcinoid Tumors with Hyperparathyroidism," *AJR* 139:1001-1004, 1982.
3. Wick, M.R., Scott, R.E., Li, C.Y., Carney, J.A.: "Carcinoid Tumor of the Thymus. A Clinicopathologic Report of Seven Cases With a Review of the Literature," *Mayo Clinic Proc.* 55:246-254, 1980.
4. Brown, L.R., Aughenbaugh, G.L., Wick, M.R., Baker, B.A., Salassa, R.M.: "Roentgenologic Diagnosis of Primary Corticotropin-Producing Carcinoid Tumors of the Mediastinum," *Radiology* 142:143-148, 1982.
5. Vener, J.D., Zuckerbraun, L., Goodman, D.: "Carcinoid Tumor of the Thymus Associated with a Parathyroid Adenoma," *Arch Otolaryngol* 108:324-326, 1982.
6. Salyer, W.R., Salyer, D.C., Eggleston, J.C.: "Carcinoid Tumors of the Thymus," *Cancer* 37: 958-973, 1976.
7. Gelfand, E.T., Basualdo, C.A., Callaghan, J.C.: "Carcinoid Tumor of the Thymus Associated With Recurrent Pericarditis," *Chest* 79:350-351, 1981.
8. Black, W., III.: "Enterochromaffin Cell Types and Corresponding Carcinoid Tumors," *Lab Invest* 19:473-486, 1968.
9. Fitzgerald, P.M., Rickard, M.T., Martin, G.E.: "The Role of Computed Tomography in a Case of an ACTH Secreting Thymic Carcinoid Tumor," *Computerized Radiology* 6:209-214, 1982.
10. Wick, M.R., Bernatz, P.E., Carney, J.A., Brown, L.R.: "Primary Mediastinal Carcinoid Tumors," *Am J Surg Pathol* 6:195-205, 1982.
11. Felig, P., Baxter, J.D., Broudus, A.E., Frohman, L.A.: ENDOCRINOLOGY AND METABOLISM. New York, McGraw-Hill Book Co., 1981.

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WISCONSIN—LAKE MICHIGAN Shoreline: Eight physician primary care group located in community of 14,000. Call shared with four family physicians in group. OB desired. Salary plus first year bonus plan. Internist, OB/GYN, pediatrician and general surgeon in group. South of Door County peninsula. Send C.V. or telephone collect: Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053; (609) 596-0661.

INTERNIST WITH SUB-SPECIALTY in rheumatology to join well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL 60178.

ILLINOIS—CARBONDALE AREA: Multispecialty group expanding services. Two physicians needed for branch clinic. Hospital located in branch clinic community. Guaranteed salary first year. Southern Illinois University is nearby. Family practice residency located in Carbondale. Group has close working relationship with SIU School of Medicine. Send C.V. or contact Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053; (609) 596-0661.

PHYSICIANS NEEDED In the Sunbelt. Clients throughout our 12-state placement area (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas) need physicians—all specialties. An M.D. does all of our placement work and through careful screening he eliminates needless interruption of your work. Send C.V. to: Trent Associates, 2421 Shades Crest Road, Birmingham, AL 35216.

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WISCONSIN—LAKE GENEVA area—Well-established family physician seeking partner. Solo options also available. Full scope of family medicine. Community of 6,000 is ten minutes from 130-bed JCAH facility. Less than one hour drive to both Madison and Milwaukee. Salary plus production incentive or guaranteed income first year. Send C.V. or telephone collect: Fox Hill Associates,

One Greentree Centre, Suite 201, Marlton, NJ 08053; (609) 596-0661.

INDIANA—LAKE MICHIGAN shoreline—family physician for 30 physician multispecialty group located in northwest Indiana, 50 miles from Chicago. Thirteen FPs in group. Practice at main clinic facility. No OB. Income guarantee plus first year productivity incentive. Retirements created vacancies. Send C.V. or contact: Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053 (609) 596-0661.

ILLINOIS: EMERGENCY PHYSICIANS needed for 407-bed hospital located in central Illinois near the state capital. Annual volume is 29,000. Physicians will cover the emergency department, convenient care clinic, and industrial medicine clinic. Excellent compensation and professional liability insurance procured on your behalf. Contact: Bob Shoemaker, Coastal Emergency Services, Inc., 6230 Busch Blvd., Ste. 300, Columbus, OH 43229; collect (614) 436-0418 west of the Mississippi R.; (800) 633-9964 east of the Mississippi R.; (800) 551-3859 in Ohio.

FAMILY PRACTITIONER/WI: BC/BE to join 23 physician multispecialty group. Progressive hospital equipped with CT scanner. Service population of 60,000/80,000. University community. Reply: Administrator, 2501 Main St., Stevens Point, WI 54481; or call collect (715) 344-4120.

WISCONSIN—FOX RIVER VALLEY—Three board certified family physicians seeking fourth. OB desired. College in community of 7,500. Excellent hospital facility in community. Call rotation every fifth night and every sixth weekend. Physicians rotate through two branch clinics. Guaranteed salary with productivity first year. Less than one half hour drive to Lake Winnebago. Send C.V. or telephone collect: Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053; (609) 596-0661.

EMERGENCY CONSULTANTS, INC. provides emergency department services to hospitals in Alabama, Illinois, Indiana, Michigan, New York, Ohio, Pennsylvania, Tennessee, Texas, Virginia, West Virginia and Wisconsin. Full time and part time positions available for career oriented emergency department physicians. Independent contractor status with competitive compensation and paid malpractice insurance. Forward C.V. with availability date and geographic preference to: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795, or in Michigan 1-800-632-3496.

ILLINOIS—PEORIA AREA: Establish satellites in three communities as members of group practices. OB desired. Two practices available in Peoria. Guarantees and other financial incentives. Send C.V. or contact Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053; (609) 596-0661.

EMERGENCY MEDICINE—Level 1 trauma center: Major university teaching hospital is conducting a search for emergency department physicians. Excellent remuneration and challenging medical environment. Interested applicants should send resume to: Frank J. Siano, Administrator, Emergency Department, The University Hospital, 1325 South Grand Boulevard, St. Louis, MO 63104.

EMERGENCY MEDICINE—Illinois: Excellent full-time and part-time opportunities are currently available at client hospitals throughout Illinois. Choose location, patient load and schedule that fits your needs. Occurrence malpractice insurance coverage and guaranteed rate of compensation. For specific details on all of our Illinois opportunities, contact Dan Patton, Spectrum Emergency Care, Inc., P. O. Box 27352, St. Louis, MO 63141; (314) 878-2280; 1-800-325-3982.

WISCONSIN—MADISON AREA—One family physician to join board certified family physician and one board certified internist located 30 minutes from downtown Madison. OB necessary. Well-equipped hospital in this community of 4,000. ER call schedule one night a week and every sixth weekend. OB call will be shared among three family physicians. Guaranteed income and full benefits. Send C.V. or telephone collect: Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053; (609) 596-0661.

UNIVERSITY HEALTH SERVICE: Board eligible/certified psychiatrist to provide psychiatric evaluation, short-term psychotherapy and supervision/consultation for other staff. Part-time or contract hours with schedule flexibility available. Illinois license or eligibility therefore. Active mental health service with eclectic approach in accredited health service. 45 minutes from suburban Chicago. University population of 26,000. Inquiries, with resume, to: Rosemary B. Lane, MD, MPH, Director, UHS, Northern Illinois University, DeKalb, Illinois 60115; (815) 753-1314, for further information, EOE/AA employer.

SITUATIONS WANTED

INTERNIST SEEKS part or full time position: days, evenings, or nights Chicago metropolitan area. Experienced in occupational/industrial and general practice. University trained. Reply to Box #1198, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

WANTED: PRIVATE PRACTICE. General or internal medicine. Chicago or near suburbs. Reply to Box #2019, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED general surgeon seeks suitable position. Willing to do some general practice. Will also consider HMO, minor surgery centers and emergency care centers. Reply to Box #2024, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

WANTED TO BUY: General practice or general practice with surgery. Prefer small or medium size community. Could take over the practice immediately. Has current Illinois license. Reply to Box #2025, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED PEDIATRICIAN seeks part-time position in Chicago and suburbs. Reply to Box #2022, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OB/GYN—BOARD CERTIFIED. Full or part time position. Chicago metropolitan area. Call (312) 267-1471.

PHYSICIAN, 63, in solo family practice for thirty years wishes to relocate in Chicago metropolitan area with group, clinic or HMO. Available April, 1987. Reply to Box #2038, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, ultrasound diathermy, surgical instruments, microscopes, etc. Please call or write Robert Shapiro at 512 Warren Road, Glenview, IL 60025; (312) 743-3900.

FOR RENT: Beautiful and well furnished office for rent for any specialty in growing area of Carol Stream, IL. Call (312) 830-3000 after 5:00 p.m.

THREE MONTHS rent free—medical office, super location in Oak Park, great parking. Two exam rooms, 1 office, 1 washroom plus reception area. $495.00. Call (312) 251-3746.

OTOLARYNGOLOGY. Well established practice for sale. Located in the professional building of a 500-bed Chicago suburb hospital. Call (312) 475-2206.

SUBLET OFFICE SPACE for doctor. Fully equipped and furnished-Drs. private office-secretary area-5 exam rooms. Near Archer and Harlem (312) 586-0811.

TWO EXAMINING TABLES for sale. Adult and pediatric with scale. Both have drawers and cabinets. Good condition. $125.00 each. Call Maria (312) 361-0615.

ADR 4000 ULTRASOUND: With linear and sector scanners, extra monitor and cart. Take over lease. For details, reply to Box #2016, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FREE RENT to start. Established medical suite. Furnished or unfurnished. 6450 N. California (corner Arthur). In prestigious air-conditioned medical building. Pharmacy, x-ray, office and complete laboratory on premises. Spacious waiting room and six-day full time experienced receptionists-switchboard operators to handle appointments paid by building. Parking lot. For appt., call: (312) 764-4000 or (312) 338-5089.

MEDICAL BUILDING for sale (6,300 square feet) or lease (925 square feet). Formerly chiropractor's office. 1497 Vandalia, Collinsville, IL. Presently divided into seven rooms. Ideal location for a medical office. Close to Oliver Anderson Hospital. Utilities included. Plenty of parking. $700. Call (314) 842-4038.

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

X-RAY MACHINE Universal 300 MA 125 KVP. Stationary table. Upright chest unit. Illinois State nuclear safety approved. New tube. Works perfectly. Ms. Moore, Treister Orthopaedics. (312) 633-5866.

BUSY FAMILY PRACTICE. Southwestern suburbs. Twenty miles from Chicago Loop. $300K gross yearly. Reply to Box #2026, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SELLING FAMILY PRACTICE Southside. Grossing $125,000. Working 3 hours. More potential if fulltime devoted. Selling cheap with equipment. Relocating. Excellent office. (312) 333-6789 evenings/weekends.

MEDICAL SUITE in busy medical clinic. Centrally located in rapidly expanding population area of Des Plaines, Illinois. Excellent opportunity for specialist or generalist. Share reception with four busy doctors. Introductory list for mailing available. Reasonable rent. Hospitals conveniently located. Des Plaines Medical Arts Bldg., Center and Thacker Streets, Des Plaines, Illinois 60016. Call (312) 824-4919.

PICKER X-RAY: Refurbished and certified equipment (fluoroscopic and diagnostic rooms). Including processor and accessories. In excellent workable condition. Incredible price—due to illness, must sell. Franklin X-Ray, Southfield, Michigan. Please call (313) 358-3410.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)244-3355, (312)662-1664.

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WESTERN SPRINGS SUBLET—Beautiful modern office available 3½ days/week. Hinsdale and LaGrange hospitals nearby. Excellent parking. Call (312) 246-4400.

SOUTHWEST CHICAGO (Summit area): General practice grossing $100,000+ including real estate available for $175,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093 (312) 441-6111.

GENERAL PRACTICE in central Illinois grossing over $350,000 a year available for very reasonable terms. Reply to Box #2037, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

TINLEY PARK Medical center: For sale. Full equipment. Full A.C. On main street. Parking, doctor's private parking—garage. Lot adjacent to office for future expansion. Near five hospitals. Shown by appointment (312) 335-4335 or (312) 532-3900 after 3 p.m.

SOUTHEAST CHICAGO. If interested in profitable industrial and general medical clinic grossing approx. $1,800,000, write Box #2035, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE: Cash or contract—seven room medical suite in condominium office building—Bloomington-Normal. Contact: J. G. Brown, M.D., telephone (309) 452-7025.

ROGERS PARK AREA radiology practice available for $47,000. This includes all equipment and practice grossing $100,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093 (312) 441-6111.

MEDICAL OFFICE for rent in southwest suburb, professional bldg. Available January 1, 1987. (312) 599-2000.

A BEAUTIFUL MEDICAL OFFICE in Zion, Illinois for lease. 1,100 sq. ft. working area (seven rooms) and 550 sq. ft. basement. Interested parties please call (312) 872-5965.

SOUTHWEST SUBURBAN (Near Oak Lawn) medical center available. Owner grossing $1,300,000 and would stay on to continue specialty work. Well equipped facility. Write Box #2036, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL OFFICE AVAILABLE: Chicago Northwest—Belmont/Austin area. Beautifully furnished medical suite. A/C; heat. Very reasonable for busy M.D. Call Michael Rabin (312) 685-2277.

MISCELLANEOUS

PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

MEDICAL PRACTICE SALES and appraisals. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004; (215) 667-8630.

A Fundamental Resource



Ideally, physicians always think of others before themselves. They are continually concerned about patients, employees and others they work with. They strive to teach new physicians through didactics and example, and to keep cognitive and procedural skills up-to-date. Ideally, each physician participates in the activities of organized medicine to make sure that quality of care for our patients, and the practice mileu, are not compromised. The ideal physician buries himself or herself in all of these activities, and sometimes does not pay enough attention to himself or herself or family members.

The holiday season is an excellent time to tend to these neglected areas. Maybe it is a time to look within our own health habits—physical and emotional. Do we exercise too little or have poor eating habits? Do we smoke or rely on alcohol to keep us going or help us rest? Do we allow stress to rule our lives? Do we realize that physicians' families have the same needs as other families—and maybe even more so, because we're absent so much?

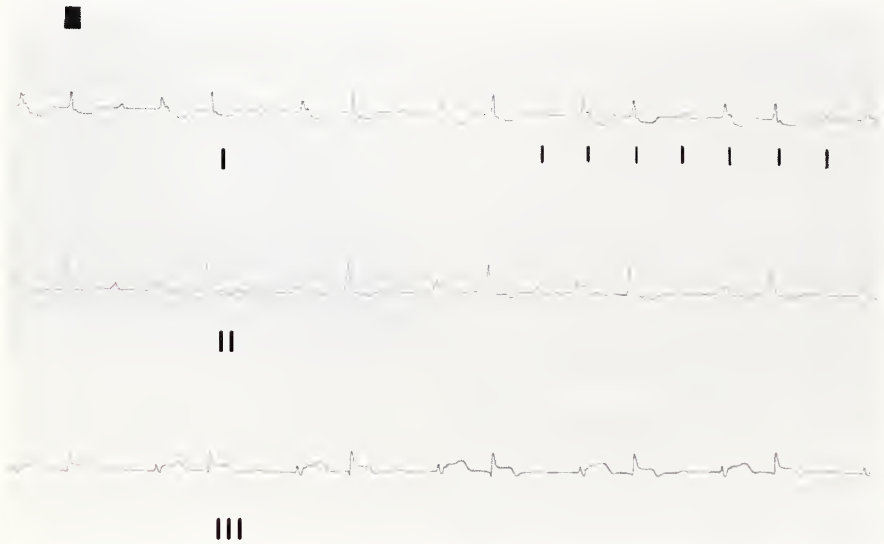
This holiday season, instead of focusing on finding time for as many parties as possible, or getting caught up in the increasingly popular "holiday blues syndrome," we might take a long look at ourselves and our families. We may have been ignoring a great source of strength and energy.

Happy Holidays!

Jere E. Freidheim, M.D.
President

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a 58-year-old woman who had had aortacoronary bypass surgery four years earlier. She did very well until five days prior to admission, when she developed severe and prolonged retrosternal chest pain. The pain radiated to the left arm and both jaws, and was associated with nausea and dyspnea.

The patient was admitted to the hospital and had an uncomplicated course for four days, at which time chest pain recurred with hypotension and an irregular heart beat. She was transferred for further diagnosis and treatment. At the time of the hospital transfer, her blood pressure was 100/58mmHg and pulse was 80 beats per minute and irregular. There were bilateral fine crepitant rales in both lung bases. A loud atrial gallop (S_4) was present, but no S_3 was heard on examination of the heart. A complete blood count showed a white blood cell count of 17,300/mm^3 and a hematocrit of 42%. A portable chest x-ray suggested a slightly enlarged cardiac silhouette and changes compatible with pulmonary edema.

Questions:

1. **This lead I, II, III simultaneous ECG rhythm strip shows:**
   A. Premature atrial beats in bigeminy.
   B. Premature ventricular beats in bigeminy.
   C. Escape-capture bigeminy.
   D. A 3:2 atrioventricular (AV) Wenckebach second degree block.
   E. Aberrant intraventricular conduction.

2. **Considerations in the diagnosis and treatment plan could include:**
   A. Pulmonary artery catheterization.
   B. Intravenous fluids and inotropic support, *e.g.*, dobutamine infusion.
   C. Intra-aortic balloon counterpulsation.
   D. A repeat coronary angiogram.
   E. All of the above.

(Continued on page 392)



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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Part of the Informed Physician's Vocabulary

Indemnification and Hold Harmless Clauses

Indemnification and hold harmless clauses are not new; contracts have included them for many years. They're not difficult to spot. The words "indemnify" and "hold harmless" are almost always used. The basic ingredient of the clause is not hard to grasp: one party assumes the liability inherent in a situation, thereby relieving the other party of responsibility. But when a contract between a physician (or IPA) and an alternative delivery system, be it an HMO or PPO, includes an indemnification and hold harmless clause, the informed physician is confronted with important, financial and legal issues.

The dynamics of the indemnification and hold harmless clause may best be illustrated by examining it in its major habitat: the commercial lease. Suppose you're renting space for your practice from the ABC Medical Tower. It is not unlikely that your lease embraces one or several promises that you, the tenant, will indemnify and hold harmless the landlord.

hold harmless\(hold harmlis)**1.** a contractual arrangement in which one party assumes the liability inherent in a situation, thus relieving the other party of responsibility. **2.** contract provision whereby one party agrees to hold the other without responsibility for liability or losses arising out of the transaction involved.

indemnify\(in dem′ na fi′) v.t., -fied, -ying**1.** to compensate for damage or loss sustained. **2.** usually intended to protect one party from loss or liability not under its control when the loss or liability is caused by conditions that are under the control of the party that is agreeing to indemnify. **3.** used in the sense of relieving a party from liability for damages.

Typically, this type of lease requires that you indemnify and hold the landlord harmless against claims and liability, including attorney's fees, for personal injuries or property damages occurring in your office space. The indemnity often extends to all claims and liabilities which are connected with alterations, additions, improvements or installations that you are permitted to make in your office. Perhaps you also have agreed to indemnify and hold the landlord harmless against all claims related to any theft or robbery committed against you in your office.

In all three of these examples, you, the tenant, exercise control over the situation involved. Generally speaking, it is within your power to keep your office safe and prevent personal injury to your employees and visitors. Under the lease, installations, additions or structural changes made within your office are made by contractors hired and controlled by you. You can create your own system to assure adequate

security and prevent theft.

Significantly, your comprehensive general liability insurance policy provides coverage for theft, personal injury and property damages occurring in your office. Ordinarily, if your landlord is sued because someone fell in your office and broke his arm, your insurance company will assume the defense and pay any liability for all concerned provided that your policy includes what is known as a "Broad Form Contractual Liability Endorsement." You are not left "bare" (without insurance protection) because of the contractual liability you assumed by your promise to indemnify, defend and hold the landlord harmless.

The indemnification and hold harmless clause in a contract between a physician (or an IPA) and an HMO or PPO is as easy to spot as it is in other contracts, because, again, the clause almost always contains the words "indemnify" and "hold harmless." The clause may look like this.

> "The Physician shall indemnify, hold harmless and defend the ABC HMO, its officers, directors, and agents from any litigation costs, claims, judgments, settlements, damages, losses and expenses, including attorney's fees and all other costs, resulting from medical care and services provided by Physician to enrollees under the terms of this contract."

Or it could simply state something like: "The Physician shall indemnify and hold harmless the ABC HMO from and against any liability arising under the contract." Of course, physicians make medical decisions whether the patient is a contract patient or not. But in some contractual arrangements, administrative foul-ups, utilization restraints and prior approval requirements may directly or indirectly affect the decision. The physician may not exercise the degree of control over the delivery of services to justify assuming full liability if anything goes wrong. That is fundamentally what an indemnification and hold harmless clause does.

Additionally, most professional liability insurance policies, including the Illinois State Medical Inter-Insurance Exchange policy, specifically exclude from coverage liabilities which the physician assumes because of a contract. And that's exactly what an indemnification and hold harmless clause is: a contractual agreement to assume someone else's liability. Professional liability insurance companies generally cover you for your actions or ommissions which comprise medical malpractice, but not for the liability of others that you assume by signing a contract. Therefore, if you assume the liability of an HMO or PPO because of an indemnification and hold harmless clause, you will most likely be doing so at your own financial risk. If you have to defend and indemnify an HMO or PPO, it may be from your personal assets.

You're an informed physician; you've consulted your personal attorney, your professional liability insurance company and your comprehensive general liability insurance company about the specific indemnification clause in the contract you are considering. You've also sent the contract to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you with objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important provisions, in addition to those which need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It is not legal advice, the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before these decisions are made.

Your attorney has undoubtedly explained that, when you are considering an *Individual Participation Agreement* with an HMO, PPO, or IPA, you may not band together with other physicians to negotiate the contract collectively, because that violates anti-trust laws. You can, however, individually negotiate your own contract with your personal attorney or financial advisor. ◂

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Who's Paying the Tab?

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwin began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

I am beginning to understand why some of your doctors express feelings of ambivalence and confusion. I receive enough mail from the medical society to feel thoroughly loved and needed. There is so much here that I am totally confused about what I should keep, what I should read, and what I should throw away.

It was a rather a busy summer and fall, so my medical research was limited to sorting the material sent to me and separating that to be read at a later time from that which seemed more urgent. I have just finished reading through the more urgent pile (and that view is mine) and hope soon to be able to respond with my second opinion on some of the issues that you and your staff and doctors have identified. Before doing that, however, I have to report on an incident in the Apollo Cafe, that has some incidental relevance to one of the medical issues I have noted.

Last week, during one of the many momentary lulls in the conversational flow, a "fuss" was heard coming from the back booth—the booth assigned to Willard and Raphe to diminish the atmospheric pollution that seems to follow them.

"I don't understand why I always buy the coffee." It was Willard, angrily storming at Raphe.

"Sadie," Raphe replied, "only gives me enough money to buy chewing tobacco, and hardly enough for other essentials, much less coffee."

Willard went on about his opinion of that for a while and ended up by demanding, "Raphe, you've gotta understand that whoever gets the money and doles it out has control of the whole situation, and Sadie has got you controlled entirely."

That created a lot of discussion by the roundtable, with folks voicing opinions in regard to monetary control. This ranged from Chic, who puts his wife on a household allowance and has been able to live with that for quite a while, to the free-thinking Chester, who figured there was no real need to worry since both he and Maude work, and have a common bank account that they both add to and deduct from.

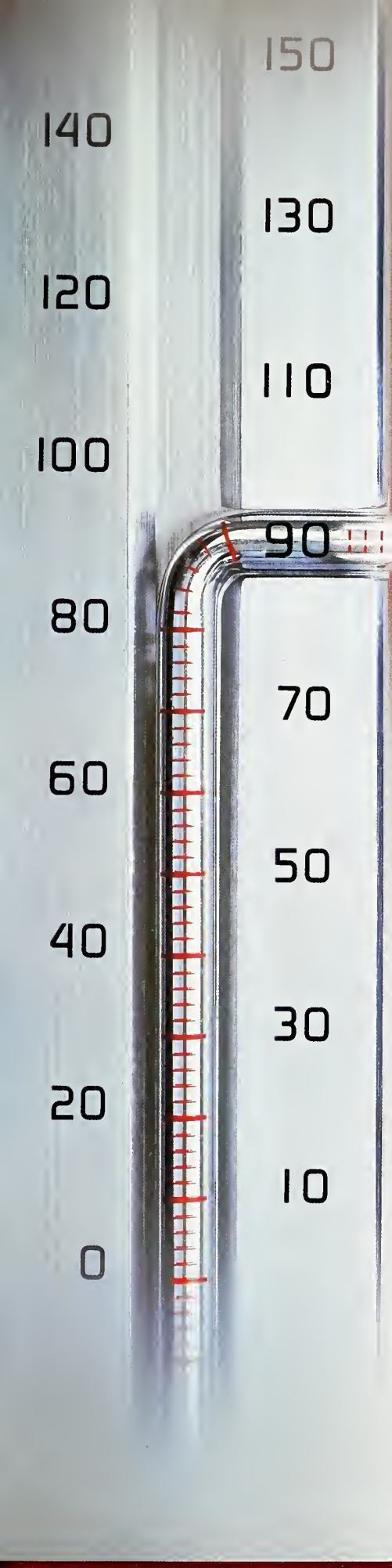
All of this triggered recollections of articles about changes in how your doctors are paid for their services. Seems that compensation has less and less to do with what you work out with patients and more and more to do with what somebody else has to say about it. That somebody else might be an insurance company or a government agency, but in any event, it comes down to a third party setting a value on what happens between a person and his doctor. Raphe was suffering from the evils of third party financial control. He was farming, bringing the money in, and Sadie was collecting it and doling some out to Raphe, thereby controlling, or at least limiting, his ability to buy coffee.

In my opinion, your doctors are suffering a little bit of the same fate. The money comes to the insurance company, or the fiscal intermediary (a new term that I learned and I thank you very much), and then is doled out to the doctors in a manner over which they have very little control. Like Raphe, they can storm and scream and stamp their feet, but they don't have control of the economic system. I suspect the same thing will happen when the hospitals under DRGs include doctors. The money will come from that "FI" to the hospitals, and then to the doctors, putting them at least two notches down on the output economic scale.

It seems to me that whoever controls the money on the front end controls the entire system, including the physicians who are at the end of the receiving line. Somehow, your doctors are going to have to get to the front end of that system, or they'll only have the gleanings to work on, while those who precede them on that particular economic money chain will get the larger share of those funds. I sure hope you all can work it out! ◀



Yours,
E. Goodwin



NEW...ONCE DAILY
IN MILD TO MODERATE
HYPERTENSION

A MORE LOGICAL COURSE OF MANAGEMENT...

...PROVEN EFFICACY AND A GREATER FREEDOM FRO



***Blanche, R.:** 47, chronic bronchitis, heavy smoker*
BP 165/105

***Alice, W.:** 65, overweight diabetic,*
BP 190/98

***James, B.:** 38, asthmatic moderate angina,*
BP 150/107

Proven efficacy...

- Reduces diastolic *and* systolic pressure regardless of age or race[1]
- Shown superior to propranolol in several clinical studies[2-4]
- As effective as metoprolol, pindolol, and labetalol[3, 5, 6]

...with established built-in benefits for optimal patient acceptance

- Low incidence of fatigue
- Mental depression, impotence rarely reported
- No adverse effect on potassium, uric acid, lipid, or glucose levels[2, 7-9]
- Safe in COPD and asthmatic patients
- Safe in diabetic patients[10]

DE EFFECTS

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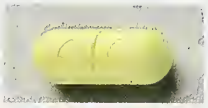
***hn, K.**: 42, confirmed diastolic BP 102, abnormal lipid profile*

***Thomas, G.**: 70, asthmatic, drug induced hypokalemia/hyperuricemia, BP 190/98*

***Peter, M.**: 53, workaholic, chronically fatigued, BP 180/92*

NEW

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ISOPTIN® SR

(verapamil HCl/Knoll)

240 mg scored,sustained-release tablets

Antihypertensive therapy you and your patients can live with

Please see brief summary for contraindications, warnings, precautions, most common side effects, and rates of occurrence.

ISOPTIN...SAFETY BACKED BY OVER 23 YEARS OF WORLDWIDE CLINICAL EXPERIENCE *

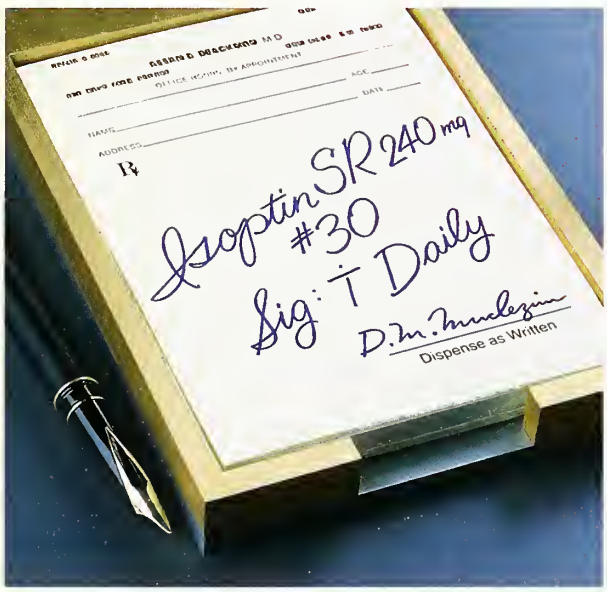
Side effects most commonly encountered with ISOPTIN

Constipation	8.4%	CHF or Pulmonary Edema	1.8%
Dizziness	3.5%	Fatigue	1.7%
Nausea	2.7%	Bradycardia	1.4%
Hypotension	2.5%	AV Block (3°)	0.8%
Edema	2.1%		
Headache	1.9%		

Above incidences of adverse reactions derived from clinical trials in 4,954 patients.

Contraindications: Severe left ventricular dysfunction, hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome or second- or third-degree AV block (if no artificial pacemaker is present).

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240 mg scored, sustained-release tablets

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ISOPTIN (verapamil HCl/Knoll) is also available as 80 mg and 120 mg scored, film-coated, regular-release tablets.

*Includes eight years of clinical experience in hypertension.

REFERENCES: 1. Cubeddu LX, Aranda J, Singh B, et al: *JAMA* 1986;256:2214-2221. **2.** Leonetti G, Pasotti G, Ferrari GP, et al: *Acta Medica Scand* 1984; suppl 681:137-141. **3.** Data on file, Knoll Pharmaceuticals. **4.** Halperin AK, Kirsten M, Gross PA, et al: *Clin Pharmacol Ther* 1984;36:750-758. **5.** Anavekar SN, Christophidis N, Louis WJ, et al: *J Cardiovasc Pharmacol* 1981;3:287-292. **6.** Anavekar SN, Barter C, Adam WR, et al: *J Cardiovasc Pharmacol* 1982;4:S374-S377. **7.** Lewis GRJ, Steward DJ, Lewis BM, et al: *In Symposium on Calcium Antagonism in Cardiovasc Ther* 1980;270-277. **8.** Leonetti G, Sala C, Bichanini C, et al: *Eur J Clin Pharmacol* 1980;18:375-382. **9.** Midtbo K, Hals O, van der Meer J, et al: *J Cardiovasc Pharmacol* 1982;4:363-368. **10.** Rojdmark S, Andersson DEH: *Am J Cardiol* 1986;57:39D-43D.

Please see brief summary on following page.

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NEW...ONCE DAILY IN MILD TO MODERATE HYPERTENSION

Brief Summary

ISOPTIN®-SR (verapamil HCl/Knoll) 240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIDNS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory 8ypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDDSAGE).

Drug Interactions: 8eta 8lockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tulerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVEROOSAGE: Treatment of overdosage should be supportive. 8eta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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Annual Meeting Scheduled

The Second Annual Meeting of the ISMS Hospital Medical Staff Section will be held Saturday, February 28, 1987, in Chicago. The meeting will be divided into a business session and an educational session.

The business session will include discussion of proposed resolutions and election of officers. The educational session will focus on risk management issues, such as credentialing, reducing suit frequency and enhancing defense against lawsuits.

All Illinois hospital medical staffs are eligible for representation at the annual meeting. Each medical staff may have one voting member in the section. Representatives must be ISMS members with active clinical privileges, and should be elected by the medical staff. Representatives to the AMA HMSS are automatically members of the ISMS section unless the medical staff decides otherwise. In such situations, ISMS should be advised of the new representative.

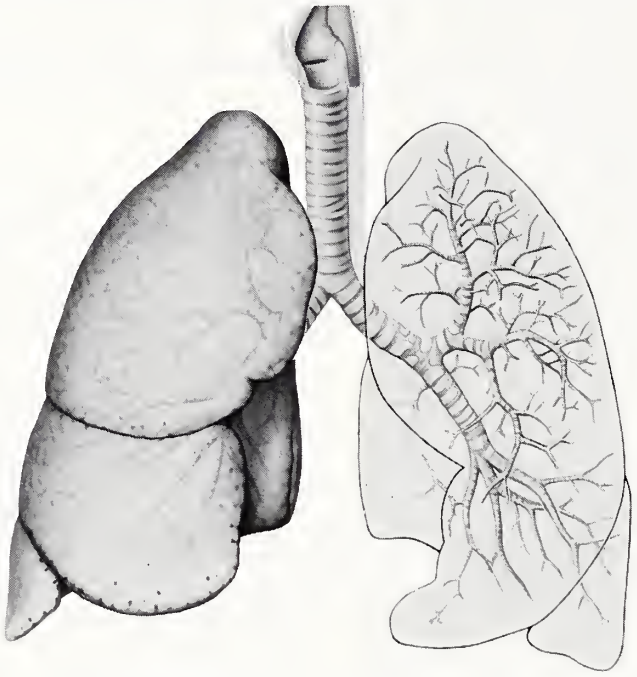
ISMS members who are not medical staff representatives may attend the educational session of the annual meeting as space permits. Registration materials will be available in the near future.

The primary function of the HMSS is to represent the medical staff viewpoint within the ISMS House of Delegates. One method of doing so is through the resolution process. Any medical staff representative may submit a resolution to the section. Deadline for introduction of resolutions is January 29, 1987. Late resolutions submitted need ⅔ vote of the section to be introduced. For assistance in drafting resolutions, contact the ISMS HMSS. Resolutions can be sent to ISMS HMSS, Suite 700, Twenty North Michigan Avenue, Chicago, IL 60602.

Elections for the following section offices will be held at the annual meeting: chairman (Cook County), vice chairman (Downstate), delegate (Cook), alternate delegate (Downstate), and two at-large members of the governing council (one Cook, one Downstate). Nominations will be via the Cook and Downstate caucuses, which will meet during the annual meeting to select candidates.

Further information may be obtained by contacting the ISMS HMSS at (312)782-1654. ◀

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae*, H influenzae, *Streptococcus pneumoniae*, *Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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Illinois Medical Journal
Illinois State Medical Society

Volume 170, No. 6
December 1986

Cardiovascular Effects of Tricyclic Antidepressants

By Arnaldo G. deCarvalho, M.D./Springfield

Tricyclic antidepressants are among the most commonly prescribed drugs in this country (about three million prescriptions written each year.)[1] Initially used as antidepressants, their indications have broadened and now include many other conditions. (Table 1)

A great deal of concern has been raised about tricyclic antidepressant use in patients with heart disease. Recent studies have opposed this view and shown that imipramine may have antiarrhythmic properties.[1] In addition, the studies indicated that these drugs do not adversely affect ventricular function, even in patients whose ventricular function is already depressed.[2] Most studies, however, relate to acute overdose or therapeutic doses administered over a relatively short time. In an effort to obtain desired results, higher doses are commonly prescribed, especially for treatment of pain syndromes. I report the unusual case of a patient, treated for a long time with amitriptyline, who developed severe left ventricular dysfunction.

Case Report

A 48-year-old white male presented with shortness of breath and diaphoresis. He dated onset of these symptoms to about the previous two weeks and he noted decreased urine flow. Near fainting spells were reported. There was no history of heavy alcohol use.

Physical examination showed neck veins distended up to the angle of the jaw. Heart rate was 120. A holosystolic murmur of mitral regurgitation and a loud S3 were audible. Auscultation of the lungs revealed expiratory wheezings, (he had been a heavy smoker for many years) and rales, mainly in the left base.

TABLE 1
Indications for Tricyclics

Enuresis in children
Panic attacks
Cluster variants
Depression
Alcoholism
Phobia-anxiety syndromes
Obsessive-compulsive neuroses
Panic syndromes

The patient had been admitted to the hospital for treatment of headache one year before. He had been on amitriptyline (225mg/daily). Dosage had been increased to 400mg/daily at that time. Amitriptyline level then was 66, nortriptyline level 26, (total level 92) (therapeutic level 150-250mg/ml).

Current medications consisted of amitriptyline, 400mg per day and prednisone, 40mg daily. This dosage had been maintained for approximately 11 months. Patient reported that when his headaches got worse, he sometimes took as much as 600mg a day of amitriptyline.

Holter monitor showed an average heart rate of 108 beats per minute with 3409 ventricular ectopic beats per 24 hours, 164 couplets, one 5 beat run of ventricular tachycardia, 42 R on T, and periods of A-V block (Wenckebach) with some pauses of 3.6 seconds. At that time, patient had been placed on digitalis, but four hours after dosing the level was <0.5.

Chest x-ray showed pulmonary vascular congestion. Electrocardiogram showed sinus tachycardia and non-specific repolarization changes. (Figure 1)

Echocardiogram showed a left ventricular end diastolic diameter of 7.3 and left ventricular end systolic diameter of 6.2. Doppler confirmed mitral regurgitation. Left ventricle was diffusely hypokinetic.

Amitriptyline was discontinued upon admission to the hospital. Levels obtained two days later were amitriptyline 445mg/ml, and nortriptyline 92mg/ml (total 537).

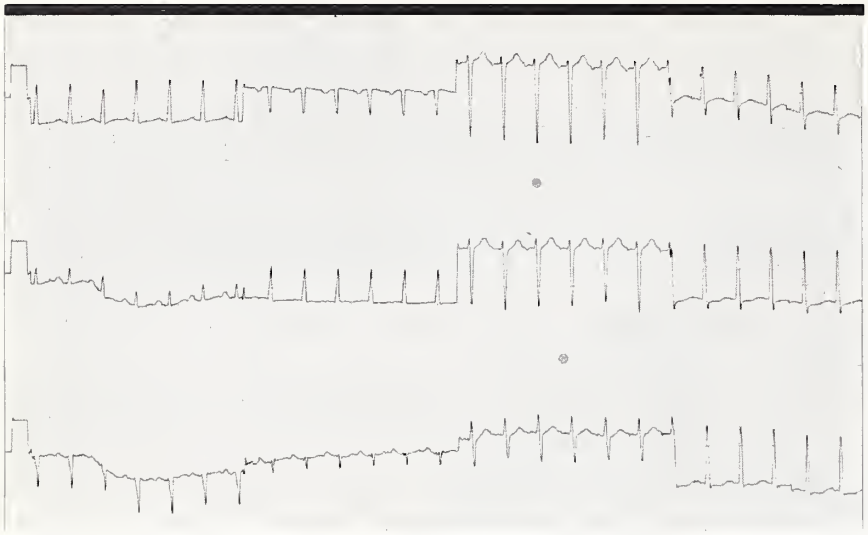


Figure 1. Cardiovascular effects of tricyclic antidepressants.

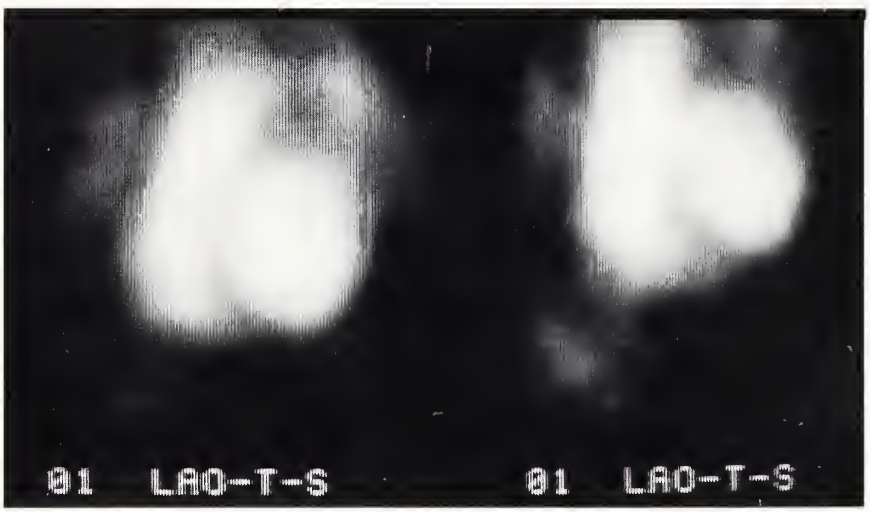


Figure 2. LAO view. End diastolic and end systolic frames of study done 17 days after admission.

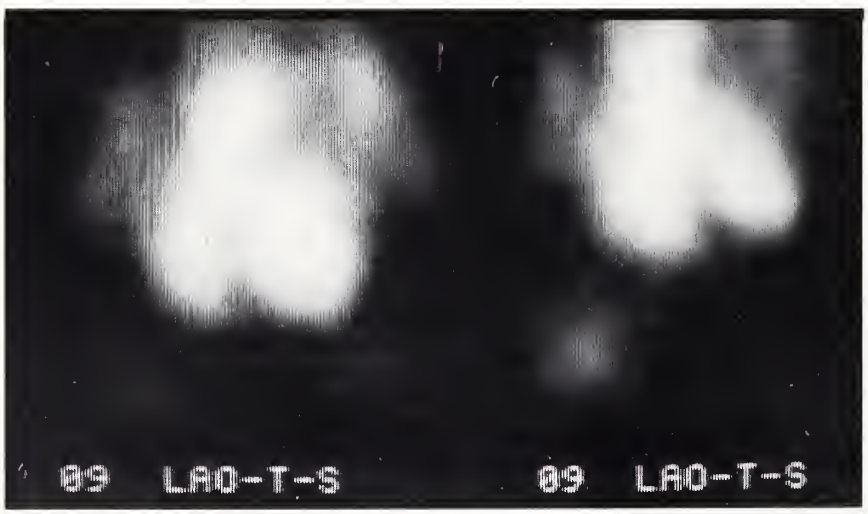


Figure 3. LAO view. End diastolic and end systolic frames of study done six months after the patient was released from the hospital.

MUGA study done seventeen days later showed 26% left ventricular ejection fraction. (Figure 2)

Cardiac catheterization performed three weeks after admission showed normal coronaries, diffuse hypokinesis, left ventricular end diastolic pressure 36, and mitral regurgitation.

Other laboratory tests showed negative gallium uptake, normal protein electrophoresis and negative acute and convalescent titers for Coxsackie virus A and B. A sedimentation rate of 10 (Westergren), ASO titer of 12, and negative blood and urine cultures were also recorded.

The patient was discharged on furosemide (40mg/daily), diazepam (5mg/qid), potassium chloride slow release tablets, prednisone (80mg/daily), oxycodone and acetaminophen, as well as tocainide (400mg/q8h). He improved markedly over the next six months and asked to resume his former activities. Holter monitor off tocainide showed 669 ventricular ectopic beats per 24 hours, 10 couplets and no periods of A-V block.

Current medications include: prednisone (30mg/daily), furosemide (120mg/daily) and clonidine hydrochloride (0.1mg/daily). When last seen, no murmur was evident and no gallop could be heard. His resting heart rate was 92 beats per minute. Repeat MUGA study showed decreased left ventricular size and 42% left ventricular ejection fraction. (Figure 3)

Discussion

The prognosis of dilated congestive cardiomyopathy is usually guarded. Objective evidence of left ventricular function improvement is usually lacking, although symptoms might improve. Tricyclic antidepressants block re-uptake of norepinephrine and serotonin, leading to an increase in their availability. In large doses, these drugs can cause the same types of cardiac abnormalities as are seen in patients with pheochromocytoma.[3] This patient was treated with clonidine in doses up to 0.8mg/daily, which were gradually reduced to the present dosage of 0.1mg/daily, for persistent tachycardia.

Although imipramine has been

reported to be of value as an antiarrhythmic agent, no such antiarrhythmic effect has been described with amitriptyline.

Most physicians treating pain syndromes prefer amitriptyline over other tricyclics. It is clear that these drugs are not interchangeable. Nortriptyline causes less orthostatic hypotension, and desipramine has much less anti-cholinergic activity than other tricyclics. Amitriptyline is probably the most widely used tricyclic in this country.[4]

This case does not negate conclusions of previous studies[5] showing that *in therapeutic doses* tricyclics are often safe for heart disease patients. An exception might be the common occurrence of orthostatic hypotension. This case emphasizes the risk of exceeding usual doses of these drugs in an effort to obtain a response. Clinicians should consider any reversible factors in patients presenting with congestive cardiomyopathy. Other agents (*e.g.*, ethanol, doxorubicin) have been shown to be cardiotoxic and discontinuation of the offending agent will not always lead to complete recovery.

A criticism could be made that this patient may have had myocarditis with spontaneous (or steroid-induced) improvement. I know of no case where progression from myocarditis to a dilated congestive cardiomyopathy was demonstrated, or where such dramatic improvement in left ventricular function was documented. Furthermore, although an endomyocardial biopsy was not done in this case, all tests for myocarditis were negative.

Summary

I have reported a possible case of amitriptyline-induced cardiomyopathy. The doses used were very high and plasma levels clearly above the therapeutic range. Marked clinical improvement has been noted and documented objectively, with a 62% increase in ejection fraction (from 26% to 42%). It is important to look for reversible factors in cases of cardiomyopathy. ◀

References

1. Giardina, E.G.V.: "Cardiac and Antiarrhythmic Effects of Imiprimine in Patients with Ventricular Arrhythmias," *Biomedicine and Pharmacotherapy* 38(3): 128-30, 1984.
2. Glassman, A.H., Johnson, L.L., Giardina, E.G.V., Walsh, B.T., Roose, S.P., Cooper, T.B., Bigger, J.T.: "The Use of Imipramine in Depressed Patients with Congestive Heart Failure," *JAMA* 250(15): 1997-2001, 1983.
3. Van Vliet, P.D., Burchell, H.B., Titus, J.L.: "Focal Myocarditis Associated with Pheochromocytoma," *New England Journal of Medicine* 274:1102-1108, 1966.
4. Veith, R.C., Raskind, M.A., Caldwell, J.H., Barnes, R.F., Gumbrecht, G., Ritchie, J.L.: "Cardiovascular Effects of Tricyclic Antidepressants in Depressed Patients with Chronic Heart Disease," *New England Journal of Medicine* 306:954-959, 1982.
5. Glassman, A.H.: "Cardiovascular Effects of Tricyclic Antidepressants," *Ann. Rev. Med.* 35:503-511, 1984.

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Arnaldo G. deCarvalho, M.D., a board certified internist with subspecialty certification in cardiovascular disease, is affiliated with St. John's Hospital, Memorial Medical Center and Humana Hospital, Springfield. A fellow of the American College of Cardiology and the American College of Physicians, Dr. deCarvalho is a clinical associate professor at Southern Illinois University School of Medicine, Springfield. He is a past president of the Sangamon County Heart Association and past vice-chairman of the Professional Education and Scientific Session committee, Illinois Heart Association.

Predicting Residency Performance

By Linda K. Gunzburger, Ph.D., Robert G. Frazier, M.D., Lih-Meei Yang, Michael L. Rainey, Ph.D., and Teresa Wronski/Maywood

This study attempts to derive a comprehensive performance index to understand the relationship between premedical and medical academic achievement and residency competence. It includes all aspects of residency competence of concern to medical educators. A resident rating form was developed identifying 18 medical care task categories. Forms were sent to the residency directors of one graduate class. The stepwise multiple regression procedure analyzed the relationship of residency performance to premedical and medical academic achievement, and selected the best predictors of residency performance. Application of the Rasch test analysis to the responses assessed the ease or difficulty of each task.

Results provide an opportunity to use premedical and medical academic achievement to predict residency competency. Annual follow-up is advised to identify aspects of the curriculum which may require change.

Prediction of physician or medical student performance at different phases of professional development is important to medical educators.[1] In the early 1960s, Price[2] applied factor analysis to 80 measures of physician performance obtained from interviews, records, and colleague opinions and found that medical school grade point average was independent of all factors having to do with professional performance. In an extensive review, Wingrad and Williamson[3] also concluded that there was little or no correlation between academic and professional performance. Several studies have shown that premedical grades and Medical College Admission Test (MCAT) scores are not useful to predict clinical competence in clerkship.[4-6] In a study of senior medical students, although different patterns of clinical competence were obtained, only grades and scientific potential could be predicted by MCAT scores and premedical grade point averages (GPAs).[7] However, supervisors' ratings of clinical competence and peer esteem were predicted from admission interview ratings and biographical background concerning personality. Other studies examining internship performances also point to this conclusion.[8,9]

A comprehensive performance index integrating all aspects of clinical competence which concern medical educators is needed. This study seeks to derive, if possible, a multi-factor performance index of duration and value.

Goals and Objectives

Our research goal was to understand the relationship of resident competency and premedical and medical school performance measures. It was our objective to be able to predict medical school performance and residency performance and competence.

The data base presently contains premedical and medical school performance data for the classes of 1982-1985, and residency competency measures for the 1982-1984 classes.

The value of the data base will increase with the number of students included. Preliminary findings are presented in this paper. These and future findings can be used to evaluate the present curriculum, as well as to suggest future direction.

Resident Competence

A resident rating form was developed to evaluate resident competence. It is sent to directors of residency training programs when the graduates are approximately seven months into the program.

The residency directors rate graduate performance in 18 basic medical care tasks. These include skill in history-taking, physical examinations, medical record maintenance, laboratory test procedures, understanding of the etiology and therapy of disease, patient and colleague relationships, emergency procedures, and learning abilities.

Data from 185 resident rating forms were analyzed by the Rasch Model, a special item analysis procedure. The Rasch Model determines item performance difficulties and provides a numeric assessment. Results showed very effective relationships with patients and colleagues, a solid ability to write medical records clearly, logically pursue symptomatology during history-taking, and perform a systematic and thorough physical examination. In the tasks of utilizing laboratory and other test procedures, understanding pathogenesis and selecting therapy, graduates performed adequately. Interviewing skills, medical knowledge, and continuous learning were areas of medium difficulty. Tasks involving research or clinical data evaluation and handling of emergencies were most difficult for our graduates.

Prediction of Resident Competence

Premedical performance data includes three grade point average (GPA) parameters: science course grades, grades on all other courses, and grades on all courses as well as the six Medical College Admission Test (MCAT) parameters. Medical school performance included final course grades in nine basic science courses and eight required clerkship courses. The grades for the medicine I, medicine II and surgery clerkships were the significant academic measures contributing to the clerkship factor. Student performances on the National Board of Medical Examiners (NBME) tests, including the total score of seven subtests for Part I, and six subtests for Part II, were also considered predictors.

Prediction of NBME

Basic science course grades are the best predictors of scores on NBME Part I. Best predictors varied from class to class. They were biochemistry or microbiology course grades for the class of 1982, neurology or pharmacology course grades for the class of 1984, and organ systems for the class of 1985. Premedical GPA or MCAT subtest scores provided moderate predictability. For the NBME behavioral science subtest, the MCAT reading and quantitative subtest scores were better predictors than the medical school basic course grades.

The best predictors for the NBME Part II also varied from class to class. Course grades earned in microbiology or the surgery clerkship for the class of 1982, pharmacology or the medicine clerkship for the class of 1984, and organ systems or the medicine subinternship for the class of 1985 were dominant. Again, the premedical GPA or MCAT was only moderately predictive. However, for the class of 1982, the MCAT quantitative subtest score was the best predictor for the NBME preventive medicine/public health subtest score.

Prediction of Medical School Course Grades

Significant relationships between premedical and medical performance were demonstrated through data from the classes of 1984 and 1985. For both classes, either the premedical total or science GPA was the best predictor for medical school course grades, especially basic science courses.

References

1. Association of American Medical Colleges: *The GPEP Report: Physicians for the Twenty-First Century*. Washington, D.C., 1984.
2. Price, P. B., *et al.*: "Measurement of Physician Performance," *J of Med Educ* 39:203-211, 1964.
3. Wingrad, J. R., Williamson, J. W.: "Grades as Predictors of Physicians' Career Performance: An Evaluative Literature Review," *J of Med Educ* 48:311-322, 1973.
4. Turner, E. V., Helper, M. M., Kriska, S. D.: "Predictors of Clinical Performance," *J of Med Educ* 49:338-342, 1974.
5. Gough, H. G.: "Some Predictive Implications of Premedical Scientific Competence and Preferences," *J of Med Educ* 53:291-300, 1978.
6. Herman, M. W., Veloski, J. J.: "Premedical Training, Personal Characteristics, and Performance in Medical School," *J of Med Educ* 15:363-367, 1981.
7. Korman, M. K., Stubblefield, R. L., Martin, L. W.: "Patterns of Success in Medical School and Their Correlates," *J of Med Educ* 43:405-411, 1968.
8. Kegel-Flom, P.: "Predicting Supervisor, Peer, and Self Ratings of Intern Performance," *J of Med Educ* 50:812-815, 1975.
9. Murden R., Galloway, G. M. Reid, J. C., Colwill, J. M.: "Academic and Personal Predictors of Clinical Success in Medical School," *J of Med Educ* 53:711-719, 1978.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The risk of coronary heart disease in heavy coffee drinkers appears to be 2-3 times that in the general population. Coffee consumption was categorized in 1130 male medical students, who were then followed for 19-35 years. The risk of myocardial infarction, angina and sudden cardiac death was 2.80 times greater in individuals drinking five or more cups daily. (LaCroix, A., *et al.: N Engl J Med* 315#16:977-82, 1986)

Early discovery of pancreatic tumor can be aided by ultrasonography, computed tomography, radionuclide scanning, duodenal drainage and cytologic examination, endoscopic retrograde cholangiopancreatography and cytology, as well as celiac and superior mesenteric angiography. These examinations are not suggested for screening, but may be indicated in patients with symptoms of jaundice, late onset diabetes, a history of cholecystectomy within the past two years and vague upper abdominal symptoms. The fact that cures may not be possible should not preclude work-ups when indicated. (Editorial: *The Lancet* 8510:785-6, 1986)

Insulin-dependent diabetes mellitus and non-insulin-dependent diabetes mellitus constitute about 15% and 80% of cases respectively. The insulin-dependent patient generally is less than 30 years old, not overweight, and prone to ketosis. These cases can be confirmed by the plasma C-peptide response after glucagon injection. Many non-insulin-dependent diabetics may also require insulin. They may also have a plasma deficient C-peptide response to glucagon associated with insulin resistance and/or impaired insulin secretion. Complications may be retinopathy, nephropathy, neuropathy, and premature atherosclerosis related to the poor glycemic control. The therapeutic regimen should therefore rest on a near-normal glycemic control. (Gerich, J.: *Mayo Clin Proc* 61#10:787-91, 1986)

High frequency transcutaneous nerve stimulation given for 15-20 minutes decreased pain 50% at rest and 11% during quad exercises in 15 patients with open knee surgery. Muscle contractibility was increased 305% compared to pre-treatment tests. The application of epidural dilute local anesthetic solution decreased resting pain 90%, and 67% on muscle contraction. Maximum muscle contraction increased 1,846%. Transcutaneous nerve stimulation is more easily administered, lacks side-effects, and can be handled by the patient. (Arvidsson, I., Eriksson, E.: *Orthopedics* 9#10:1346-51, 1986)

The routine use of 12-lead electrocardiogram on hospital admission and preoperatively was reviewed. Clinical judgement should guide physicians in ordering routine ECG. Indications for testing may include heart disease and arrhythmias, men 40 years of age or older, women 55 or older, use of medication with potential for cardiotoxicity or electrolyte disturbances, and systemic disease associated with unrecognized cardiac abnormalities. (Goldberger, A., O'Konski, M.: *Ann Intern Med* 105#4:552-7, 1986)

A study of benign headaches associated with coitus or masturbation has attributed 24% of cases to muscle contraction, 69% to vascular causes, and 7% to low cerebrospinal fluid pressure. Its incidence has ranged from .2%-1.3%, with male predominance 4:1, occurring between the ages of 30-60. Clinical features that may indicate serious intracranial pathology may include vomiting, decreased level of consciousness, meningismus, pain lasting beyond 24 hours, and focal neurologic deficits. Rupture may occur in aortic aneurysm and arteriovenous malformations. Propranolol may be effective in vascular cases; muscle relaxation techniques are recommended for muscle contraction headaches. Patients might also require reassurance and support to alleviate the emotional trauma that may be caused by this problem. (Johns, D: *Arch Neurol* 43#11:1158-60, 1986)

The preoperative peripheral lymphocyte count may indicate severity and prognosis in patients with Crohn's disease. Nearly 30% of Crohn's disease patients requiring operative treatment have a severe peripheral lymphopenia. These patients had a higher incidence of skip areas and epithelioid granulomas than those with a higher lymphocyte count. Three-year postoperative follow-up showed a significantly higher recurrence rate in cases with preoperative lymphopenia. (Heiman, T. *et al.: Ann Surg* 203#2:132-5, 1986)

Cod-liver oil supplements were given to seven pigs, and 11 pigs served as controls to determine its effect on a high atherogenic diet. Both the control and fish oil group exhibited severe hyperlipidemia, yet those pigs on cod-liver oil supplementation showed a smaller number of lesions in their blood vessels and less luminal encroachment. Platelet arachidonate was reduced, platelet eicosapentaenoic acid was increased and serum thromboxane was decreased. The dietary cod-liver oil appeared to retard the development of coronary artery disease, possibly through changes in the prostaglandin metabolism. (Weiner, B., *et al.: N Engl J Med* 315#14:841-6, 1986)

ISMS All-Member Conference Recap

Dissecting the Issues and Setting the Strategy

Physicians seeking to further reform the legal system as it relates to medical malpractice can expect intense opposition. And sunset review of the Medical Practice Act should be closely monitored. That was the consensus of most presenters at the Illinois State Medical Society All-Member Conference in Oak Brook on November eighth. The day-long conference kicked off the Illinois medical community's legislative program for 1987.

Legislative reforms to cap noneconomic damages and revise the statute of limitations for minors were the subject of scrutiny and debate at the ISMS All-Member Conference. Although most speakers stressed the monumental nature of the challenge facing physicians, the conference began on a positive note. Pointing to passage of the Society's 1985 reform legislation, ISMS President Dr. Jere E. Freidheim reported that—for the first time in the history of the Illinois State Medical Inter-Insurance Exchange—more malpractice suits had been closed than opened in a single year.

Judge Edwin Berman, who serves as administrator of the Medical Malpractice Reform Act of 1985 for the Cook County Circuit Court, also cited progress. Judge Berman reported that malpractice suit filings against physicians in Cook County were down by two-thirds since the Act was passed by the General Assembly. "It is apparent that (the new law) has done away with the frivolous lawsuit," Judge Berman said.



Cook County Circuit Court Judge Edwin Berman reviews the Illinois Supreme Court decision upholding four of five challenged provisions of the Medical Malpractice Act of 1985.

The judge went on to explain the Supreme Court's ruling that upheld most provisions of the 1985 law. The only section not affirmed by the Court was that which would have created pretrial screening panels. Judge Berman applauded the Supreme Court's action, saying that the screening panel would have been an expensive undertaking with an effect comparable to ordinances against radio playing on Chicago's transit system.

Judge Berman predicted that physicians actually would see a rise in the average settlement or verdict in a malpractice case. "Obviously, you're going to have a better case filed now," the judge explained. He added that physicians should not be alarmed by "average" statistics, predicting that total dollars awarded would decrease due to elimination of most frivolous suits.

As administrator of the new malpractice legislation for the Cook County Circuit Court, the judge vowed to work hard to see that suits are resolved as quickly as possible. "Every day that a suit remains viable is a day too long," Judge Berman said.

Stumbling Blocks Expected

After Judge Berman's analysis of the Society's past reform victory, the focus turned toward the upcoming drive for caps on noneconomic damages and a revised statute of limitations for suits involving minors. In a special videotape presentation, opponents to further reform gave their views on caps and a revised statute.

"I don't believe in caps," said Sen. Philip Rock (D-Oak Park) president of the Illinois Senate. Sen. Rock said he has seen "no demonstrable correlation" between caps and reduced insurance rates.

"To try to put a dollar limit as a matter of public policy on permanent disfigurement or pain and suffering seems to me to be just going in the wrong direction," Sen. Rock said. "I think there are other measures that can be taken—that were taken—and I think it's important that we wait and see how effective they are."

Senator Rock also expressed reservations about revising the statute of limitations as it applies to suits involving minors. "That question I don't think has been adequately discussed. I don't know what the impact will be," Sen. Rock said. However, he indicated that physicians may find the General Assembly somewhat more willing to address the statute of limitations issue than to impose caps on noneconomic damages.

"If we're going to lessen the statute of limitations, we'd better be in a position to say this is the reason we're doing it; the reason we're doing it is that there is more predictability, there will be a lesser insurance premium, and there will be more insurance available," the Senate president said. "If you can make that connection, I think the question of the statute of limitations will be an easier one to surmount than will the question of caps."



Former Illinois State Representative Sam Vinson (L) an attorney and legislative consultant, and Saul Morse, ISMS legislative counsel, coordinated a forum for debate of the issues related to 1987 legislative objectives.



Plaintiff attorney Thomas Demetrio presents an alternative viewpoint on ISMS legislative goals.

Attorney Opposition Detailed

Philip Corboy, noted plaintiff attorney, also appeared on the videotape, and urged physicians to give more thought to the ramifications of caps on noneconomic damages before rushing forward with legislation. "I would like to think that one of these days the doctors will grasp the situation that perhaps caps on damages are a terrible, terrible thing for their children and their wives and themselves if they ever get hurt," Corboy said. "I represent a lot of doctors in malpractice cases," Corboy added, "and they don't want caps."

Corboy also decried physician arguments that the legal system is out of balance. "Can it be logically said that a jury system which finds in favor of doctors two out of three times is illogical when it enters a large sum of money on behalf of the one out of three?" asked Corboy. "That doesn't make sense."

"Juries are not throwing money away indiscriminately," he added. "Jurors are not passing money from one entity to another without thinking about it. They are very discriminating."

Support Among Legislators

Also speaking in the videotape presentation (which was completed before the November elections) were legislators who support the Society's efforts to gain further malpractice reform.

Representative Alfred G. Ronan (D-Chicago), a sponsor of the 1985 legislation, warned that trial lawyers were working hard politically to see that legislators opposed to further reform were elected to the General Assembly during the November 4 elections.

"The amount of dollars that (the trial lawyers) are spending in Illinois has to have doubled and possibly even tripled from the dollars they spent during the 1984 cycle," Rep. Ronan said. "I'm not sure that the physicians are keeping up at that same rate."

Senator David Barkhausen (R-Lake Forest), another proponent of further reform, said that he believes physicians "have a strong argument on the merits" with respect to caps on noneconomic damages. "If you look at damages for personal injury cases across the board, you will see greater verdicts and settlements for similar injuries and similarly situated plaintiffs than you will in automobile accident cases," Sen. Barkhausen said. He urged physicians to use this anomaly to argue for fairer treatment under the law.

Different damage awards for similar injuries was a major point of discussion that followed the videotape. ISMS legislative counsel Saul J. Morse raised the point at that

Luncheon Speaker F. Lee Bailey

The discussion of the state of the legal system carried over to lunch, when nationally-renowned criminal defense lawyer F. Lee Bailey discussed his view of today's legal system. Recapping for physicians a history of abuses in the personal injury reparations system, Bailey said the process today "is not a very efficient way to transfer money from A to B. So little of what you pay goes to the purpose of why you pay it—to compensate a legitimately injured party," Bailey told physicians.

Bailey questioned whether jury trials are really needed in civil cases. He cited compulsory arbitration or a no-fault system as possible alternatives.

The most serious threat posed by today's liability situation is that it inhibits physicians from trying new and more risky procedures, according to Bailey. He said that without some relief, "American medicine will fall further behind other quadrants of the world."



Criminal defense attorney F. Lee Bailey told physicians that certain personality traits can have a disproportionate impact on witness credibility.



Sen. Judy Baar Topinka (R-Riverside) makes predictions on the impact of November election results.

time. Former Illinois State Representative Sam Vinson, an attorney in private practice and legislative consultant, said, "The point that ultimately sold me is that a similar injury caused by a negligent doctor is treated differently from that caused by a negligent driver." Mr. Vinson, a staunch supporter of medicine who recently retired from the General Assembly, encouraged physicians to stress this inequity when attempting to persuade legislators to adopt caps on noneconomic damages.

Former Rep. Vinson expanded on the rationale behind the drive for caps on noneconomic awards with a brief history of the tort system, which dates to twelfth century England. "One point lawyers like to make is that we are a society of laws, not a society of men," he concluded. "If no broad rules govern the conduct of the jury, then we are a society of arbitrary men again, not a society of laws."

Mr. Vinson cautioned that physicians should not attack the jury system when arguing for further reform. "One of the most important things to remember," he said, "is that legislators get there by being elected." And since most people strongly believe in the jury system, he concluded, arguments against it "will fall on deaf ears."

Prospects for Reform

After Vinson and Morse had offered their advice in preparing physicians to argue for additional legislation, attention turned toward the prospects for achieving such reform.



Rep. Jack Kubik (R-Forest Park) warned physicians that this would be "a crucial year for medicine."

Senator Judy Baar Topinka (R-Riverside) reported that physician prospects had not been enhanced by the November 4 elections. "The retention of Democratic majorities in both the House and Senate following the November elections continues to make the effort for reform a difficult task," said Sen. Topinka.

However, Rep. Jack Kubik (R-Forest Park) said physicians should not be discouraged by the election results, and encouraged physicians



ISMS Board of Trustees Chairman Alfred J. Kiessel, M.D., rises to debate a point.

to continue personal efforts. "To allow your lobbyists to do all the work is the easy way out," Rep. Kubik said.

"And if you lose on an issue, don't stop," warned Rep. Kubik. Citing the upcoming expiration of the Medical Practice Act, he explained, "A legislator who is not with you on caps may agree on the Medical Practice Act."

Joining Sen. Topinka and Rep. Kubik on the panel was Thomas Demetrio, a law partner in the firm of Corboy and Demetrio. Mr. Demetrio had asked to appear before the 300-plus physicians and spouses to convince them that their quest for caps should not be undertaken. He warned physicians that they would "meet legislators who are more educated" on the issue than had been the case in 1985. Citing statistics used by trial lawyer groups in the 1985 professional liability reform battles, Mr. Demetrio said he didn't think that the amount of malpractice costs contained in the overall health care bill was significant.

Mr. Demetrio's statement that his legal malpractice insurance premium had been astronomically increased was greeted with applause.

Mr. Demetrio repeated a charge often used by trial lawyer groups, namely that the insurance industry is the culprit in the malpractice problem. Alfred J. Kiessel, M.D., chairman of the Illinois State Medical Society's Board of Trustees, defended the physician owned and operated Illinois State Medical Inter-Insurance Exchange.



Sen. Emil Jones urges physicians to stay abreast of proposed changes in the Medical Practice Act.

Techniques Offered

The afternoon session of the All-Member Conference was devoted to instructing physicians in useful techniques to convince legislators. An audio-visual presentation designed to encourage physician participation in the latest effort was previewed for those in attendance. Copies of the presentation will be shared with county medical society and hospital medical staff action teams to help encourage local physicians to join the latest initiative. Senator Rock's comment from last summer's debate on general caps, which is reprinted on this month's cover, is an example of the historical perspective provided by the slide show.

Working with the Media

Kathryn Pratt, medical reporter for WBBM-TV in Chicago, offered advice for enlisting the media in support of additional malpractice reform. She provided particular insight into dealing with television reporters, explaining that physicians must learn to deal with a reporter's preconceived notions, air time constraints, and the need to be especially "quotable." (Editor's Note: see story on page 383).

Action Team Planning

ISMS President-Elect Dr. Allan L. Goslin recapped the elements of the action team concept that had worked so well during the 1985 malpractice initiative. He urged each county medical society and hospital medical staff to organize an action team with physician members assigned responsibility for legislator contact, community liaison, and media relations.

Dr. Goslin encouraged the addition of key hospital officials to action teams, including administrators, governing board members, medical staff coordinators, attorneys, and public relations directors. Other parties suggested by Dr. Goslin included auxilians, nurses, dentists, podiatrists, and other allied health professionals.

Armed with advice on how to conduct the upcoming battle, conference participants disbanded to form work teams organized by legislative district.

Medical Practice Act Set for Rewrite

When legislative strategy sessions concluded, conference participants reconvened for presentations on what might be expected in the course of sunset review required before the Medical Practice Act is automatically repealed on December 31, 1987. The session featured Dr. Alfred J. Clementi, former chairman of the ISMS Board of Trustees, and Sen. Emil Jones, Jr., (D-Chicago) chairman of the Senate Committee on Insurance, Pensions and Licensed Activities.

The General Assembly is re-



Physicians attending the ISMIE Network breakfast air comments and concerns about the malpractice insurance climate.

Tips For Working With the Media

Physician success in gaining additional malpractice reforms may well hinge on their ability to enlist media support. In an address before the ISMS All-Member Conference, Kathryn Pratt, medical reporter at WBBM-TV in Chicago, had some useful tips for physicians.

In her presentation to educate physicians in working with the media, WBBM-TV correspondent Kathryn Pratt said that physicians may not always relate well to members of the media, especially when interviews with them are reported differently than anticipated. "You, as the medical community, represent the establishment. We, as reporters, represent the people," said Pratt.

But she stressed that physicians can be successful in winning over reporters. "You have to learn to play the game," Pratt said. "You might even have fun."

Following are several of Pratt's suggested rules for communicating effectively with members of the media:

—Do your homework. Never go into an interview cold. Figure out what message you want to communicate and stick with it.

—Everything should be said from the public's point of view. Try not to sound self-serving—but if you have a vested interest don't deny it.

—Talk in personal tones. Don't use highly technical or legal terms. Be simple and straightforward.

—Don't divulge information you don't want used. "Off the record" only deletes your name from the story—not the reporter's ability to repeat the information.

—State the most important fact first. Don't lead up to a point. Broadcast reporters and editors look for usable segments of an interview, and they tend to use the first one they see when they're in a hurry.

—Don't argue with a reporter. You'll always lose.

—Tell the truth. Even if it hurts.

—Give a direct answer to a direct question. Then try to squeeze in your points.

—Don't be afraid to say "I don't know." If you can't answer a question, tell the reporter you will get back to him or her later if possible.

—Don't exaggerate the facts.

—Learn the art of giving good "sound bites." Try to be quotable. But above all, be brief. Most TV interview segments are only 12-20 seconds long.

—Try to be positive. There's already enough bad news to report. ◂



WBBM-TV medical reporter Kathryn Pratt gives physicians practical tips for working with members of the media.

quired to review the medical licensure act and consider any proposed amendments prior to its renewal. Sen. Jones provided a legislator's view of major issues likely to arise in the context of Medical Practice Act debate. He indicated that the General Assembly would probably focus on disciplinary provisions in the Act. The senator anticipated that consumer groups would seek input on that and other provisions, and warned that the consumer movement for mandatory Medicare assignment as a condition of licensure would likely reach Illinois.

A number of licensure acts pertaining to allied health professionals will also sunset in 1987, and Sen. Jones highlighted issues likely to arise in those deliberations. The Illinois Nurses Association was expected to offer a major rewrite of the Nurse Practice Act, he said, including provisions to require that registered nurses have bachelor of science degrees. The psychologists, social workers, pharmacists, chiropractors, optometrists, and podiatrists would also come up under sunset, he told participants, and each could be expected to suggest changes in their own acts which might have an impact on medical practice.



George T. Wilkins, Jr., M.D., Edwardsville, (center) IMPAC chairman, presented plaques to physicians representing several Illinois hospital medical staffs which made significant contributions to IMPAC in 1986. Shown after the presentation are (L-R) George Ruiz, M.D., Homewood, Robert E. Field, M.D., Harvey, Dr. Wilkins, James H. Andersen, M.D., Oak Brook, and Adriano Olivar, M.D., Flossmoor.

Senator Jones warned physicians that sunset review could bring out

Attorney General Honored for Malpractice Law Defense

Illinois Attorney General Neil Hartigan (D-Chicago) was feted at an evening cocktail reception for conference participants. ISMS Past President Dr. Robert C. Hamilton presented a plaque from the Society lauding the steadfast efforts of the Attorney General's office to support quality health care in Illinois. Dr. Hamilton recalled the successful defense of the Medical Malpractice Act of 1985 before the Illinois Supreme Court (which was conducted by the Attorney General's office) and applauded Hartigan's consistent record as a fair administrator and effective law enforcement official.

The attorney general acknowledged the plaque by stating that his work with the Society over the years—ferreting out Medicaid fraud, seeking nursing home reform, and defending the malpractice law—had been its own reward. ◀



Illinois Attorney General Neil F. Hartigan (L) accepts plaque citing his leadership and commitment to quality health care in Illinois from ISMS Past President Robert C. Hamilton, M.D., Chicago.

any number of unexpected but significant changes in medical licensure requirements. He urged conscientious vigilance as the Act moved through the legislative review process. "A grassroots movement on the scale of your 1985 tort reform effort may be needed to preserve important aspects of the Medical Practice Act," he told the group.

Medical Discipline: Recent History Recapped

Alfred J. Clementi, M.D., who chaired the Governor's Task Force on Medical Discipline, summarized activity in review of the Medical Practice Act to date.

In 1984, Governor James R. Thompson appointed a Medical Malpractice Task Force to study issues arising in the overall tort reform debate. That task force called on both the medical and legal professions to improve professional discipline.

The medical profession responded to the Task Force's recommendation by asking the Governor to form another task force, this time with the specific charge to improve medical discipline.

The Task Force on Medical Discipline presented its final report in May of 1986. It addressed several proposals to improve the quality of medical care in Illinois. It called for specific measures to identify health care providers who may not be providing quality care, and provided mechanisms that would protect patients and physicians' rights in ascertaining whether or not quality care was being provided.

The Task Force specified ways to protect the public from impaired physicians and ways to help the impaired physician return to health. Finally, the Task Force urged improved staffing of regulatory agencies so that appropriate and timely attention could be given to complaints.

Dr. Clementi emphasized professional responsibility to support workable provisions for medical discipline and to maintain high educational standards for licensure. He echoed Sen. Jones in stressing that physicians as guardians of the public health must be alert to any proposed changes in the Medical Practice Act. "To protect our patients, we must work hard to assure that the Medical Practice Act provides solid criteria for training and discipline," he said.

Call to Action

Chicago Medical Society Past President Dr. Harold Jensen wrapped up the conference with a call for prompt, decisive independent action. The time to contemplate had ended, he told the group. The 1987 legislative battle would be just that: an uphill effort that required total commitment. "You have the facts," he said, "now get going!" ◀

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

OBITUARIES

***Diamond, Sidney A.,** Sarasota, Florida (formerly of Chicago), died October 14, 1986 at the age of 77. Dr. Diamond was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

****Dilts, Preston V.,** Ann Arbor, Michigan, died October 11, 1986 at the age of 85. Dr. Dilts was a 1933 graduate of Northwestern University Medical School, Chicago.

****Hammond, Kenneth H.,** Hoopeston, died September 21, 1986 at the age of 83. Dr. Hammond was a 1932 graduate of the University of Health Sciences/Chicago Medical School.

***Kremer, Otto L.,** Columbia, died October 14, 1986 at the age of 64. Dr. Kremer was a 1948 graduate of the Medizinische Fakultat der Ludwig Maximiliams-Universitat, Munchen, Bayern, Germany.

****Lucy, Lucia H.,** Libertyville, died October 22, 1986 at the age of 85. Dr. Lucy was a 1928 graduate of Rush Medical College, Chicago.

****Margliano, Anthony C.,** Joliet, died October 25, 1986 at the age of 83. Dr. Margliano was a 1932 graduate of the University of Health Sciences/Chicago Medical School.

***Moore, Gordon F.,** Alton, died September 29, 1986 at the age of 77. Dr. Moore was a 1940 graduate of the Washington University School of Medicine, St. Louis.

****Nedoss, Hyman P.,** Schaumburg, died October 25, 1986 at the age of 84. Dr. Nedoss was a 1928 graduate of Northwestern University Medical School, Chicago.

***Rosen, Simon M.,** Chicago, died October 15, 1986 at the age of 67. Dr. Rosen was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Shulman, Myer,** Pittsfield, died October 10, 1986 at the age of 72. Dr. Shulman was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

****Wunsch, Charles L.,** Green Valley, Arizona (formerly of Aurora), died October 7, 1986 at the age of 80. Dr. Wunsch was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

DOCTOR'S NEWS

RESOLUTIONS DEADLINE

The ISMS House of Delegates' annual meeting will convene Friday through Sunday, April 10-12, at the Westin O'Hare Hotel. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 10, 1986. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accord with House policy, resolutions will be published in the *Journal* by author and subject only. Resolutions received in the ISMS offices by an earlier deadline, February 9, will be published in the March *IMJ*.

RESEARCH GRANT

A $50,000 research grant is being offered by Pfizer Hospital Products Group for an original invention in the device area. The award will recognize an individual or research team for excellence in medical device innovation. Application deadline is January 30, 1987. Information may be obtained by writing: George Flouty, M.D., Pfizer Hospital Products Group, 235 East 42nd St., New York, NY 10017, Attn: Award for Innovation.

PHYSICIANS IN THE NEWS

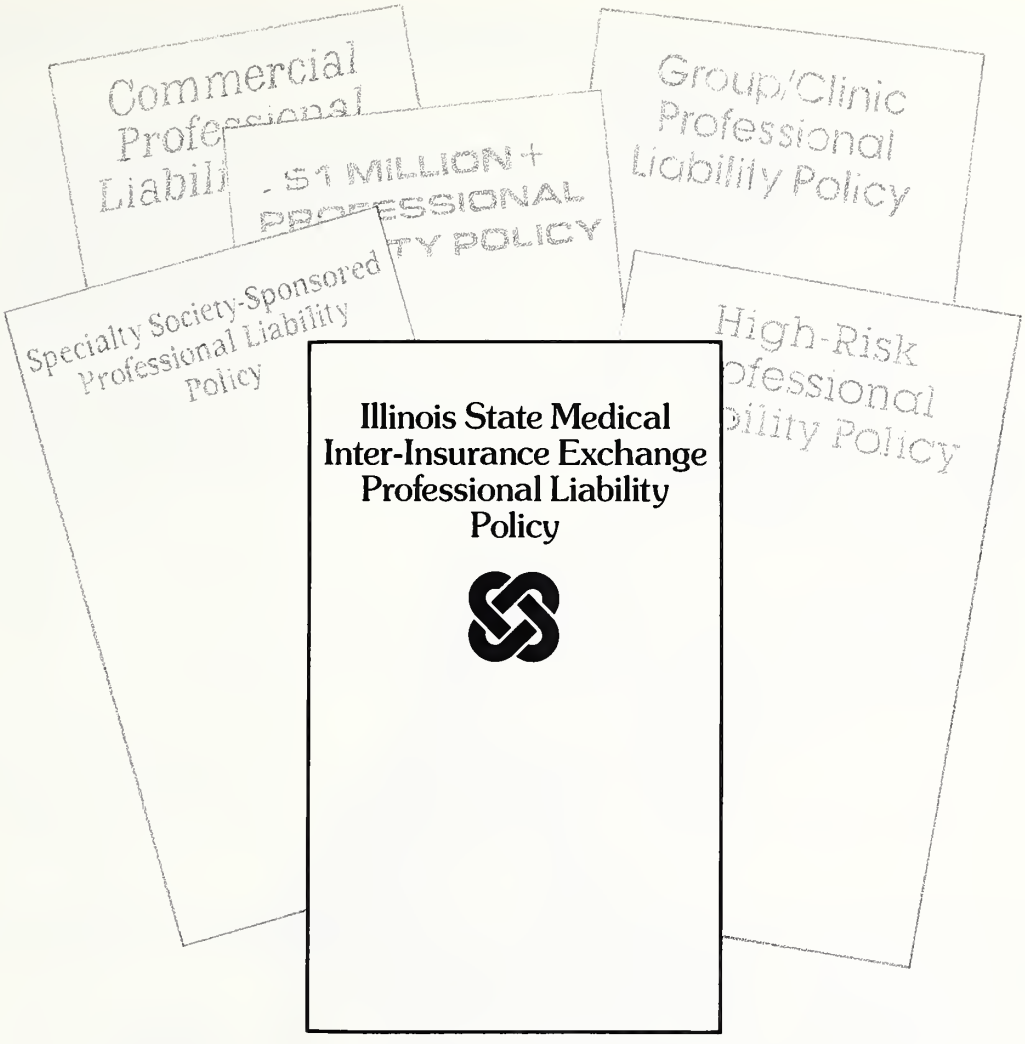
Augusta Webster, M.D., Chicago, has been named recipient of the 1986 Mary Thompson M.D. Award. Dr. Webster is former chairman of the department of obstetrics at Cook County Hospital and professor emerita of obstetrics and gynecology at Northwestern University Medical School.

EXCHANGE ANNUAL MEETING APRIL 8

The Illinois State Medical Inter-Insurance Exchange will hold its annual meeting on Wednesday, April 8, 1987 at 4:00 p.m. at the Westin O'Hare. At that time, members of the Exchange's Board of Governors will be elected. Members of the Board shall be elected by a majority vote of the members represented at the annual meeting in person or by proxy.

The Board of Governors has general supervision over the finances of the Exchange and of its operations, and establishes all policies governing the proper transaction and conduct of the business and affairs of the Exchange.

Any member of the Exchange interested in serving as a governor should so notify, *in writing*, Fred Z. White, M.D., chairman, Board of Governors, Illinois State Medical Inter-Insurance Exchange, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. Please include a current curriculum vitae. All letters of intent received at the Exchange office on or before January 30, 1987, will be considered by the nominating committee. ◀



A disappearing act?

The number and size of damage claims against physicians continues to rise. And it's drying up most sources of malpractice insurance for Illinois doctors.

But there's one company that will still be here even if all the others are gone. The Illinois State Medical Inter-Insurance Exchange.

The Exchange is a company owned and operated by its policyholders. As such, we put our policyholders ahead of profit.

Unfortunately, the Exchange is not immune from the ravages of the current legal situation. The shrinking availability of backup insurance protection is forcing us to offer only claims-made policies after July 1.

But even with claims-made, we intend to make sure that Exchange policyholders will continue to have the best professional liability protection available. The same aggressive defense of frivolous suits. And programs to help you avoid the incidents that can lead to malpractice suits.

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

January

Surgery

Specialty Review in Thoracic Surgery
For: Thoracic surgeons, general surgeons and cardiovascular surgeons. Lecture, January 5-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee**: $705. **Reg. Limit:** None. **Credit:** Category 1: 47 hours. **Contact:** Robert J. Baker, M.D. **Phone**: (312) 633-2600.

Pathology

Physicians' Office Testing
For: Pathologists and clinical chemists. Lecture, January 12, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit**: None. **Credit**: Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Family Medicine

Ventricular Arrhythmia Update
For: Family and general practitioners, internists, and cardiologists. Conference, January 17, St. Louis, MO. **Sponsor**: St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104. **Fee**: None. **Reg. Limit**: None. **Credit**: Category 1: 6 hours; AAFP Prescribed: 6 hours; and AOA: 6 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

February

Pathology

Overview of Chicago Blood Banking; Controversies in Blood Banking: Direct Donation
For: Pathologists. Lecture, February 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee**: None. **Reg. Limit**: None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Surgery

Review Course in Neurological Surgery
For: Neurosurgeons, neurologists. Lecture, February 6-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee**: $880. **Reg. Limit**: None. **Credit**: Category 1: 104 hours. **Contact:** Robert J. Baker, M.D. **Phone**: (312) 633-2600.

Specialty Review in General Surgery, Part II
For: General and specializing surgeons. Lecture, February 16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880. **Reg. Limit**: None. **Credit**: Category 1: 103 hours. **Contact**: Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Neurology

The Biologic Basis of Neurology and Psychiatry
For: Neurologists and psychiatrists. Lecture, February 23-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee**: $670. **Reg. Limit**: None. **Credit**: Category 1: 42 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

MARCH

Clinical

43rd Annual Midwest Clinical Conference
For: Physicians of all specialties, March 6-8, Chicago. **Sponsors**: Chicago Medical Society, 515 N. Dearborn, Chicago, IL 60610, and 40 contributing specialty societies. **Fee**: Pending. **Reg. Limit:** None. **Credit**: Category 1: 20 hours. **Contact**: Christine Ricker. **Phone:** (312) 670-2550, Ext. 254.

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EKG

(Continued from page 362)

Answers: 1. D, E 2. E

The basic rhythm was sinus at a rate of 115 beats per minute. The P waves were conducted to the ventricles in a 3:2 AV pattern. The black bars at the right of lead I mark the P waves. The long PR interval of the first beat of the AV Wenckebach sequence lengthened further in the second conducted beat, and the third P wave failed to conduct to the ventricles. Although all the QRS complexes were conducted from the sinus, they were morphologically different. This slightly aberrant intraventricular conduction is not sufficiently severe to cause a prolongation of the QRS duration. In order to tell which of the two beats is conducted aberrantly in this case, as well as diagnose the acute inferior myocardial infarction, more conducted beats and the twelve lead ECG would be needed.

In these tracings, beats 2, 4, 6, 8, 10, and 12 are normally conducted, and show a current of injury or ST segment elevation in lead III. The beats that terminate the longer RR cycles were aberrantly conducted. This long cycle aberrancy is less common than short cycle aberrancy, but is more often associated with diseased hearts.

The clinical diagnosis of heart disease in our patient was acute inferior wall myocardial infarction with cardiogenic shock. Right heart catheterization confirmed a low cardiac index with a pulmonary capillary wedge pressure of 28mmHg and a pulmonary artery pressure of 52/28mmHg. The arterial pO_2 was 50mmHg. Intravenous dobutamine was started, with some improvement in the cardiac index. When further hypotension occurred, an intra-aortic balloon pump was placed in the descending aorta for circulatory support. At this point, the patient was stable, but critically ill with a poor prognosis.

A coronary arteriogram would allow a full assessment of the patient's problem. A digital subtraction left ventricular angiogram showed a diffusely hypokinetic ventricle with no distinct aneurysm. The right coronary artery was totally occluded proximally. The left circumflex artery was small with diffuse obstructive disease. The left main coronary artery was normal. The left anterior descending artery had a severe proximal obstruction, but was filled by a patent aortocoronary vein bypass graft. After five days' circulatory support, the intra-aortic balloon pump was removed. Cardiac index at this point was borderline low. Two days later the patient developed a massive cerebral vascular accident and died.

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February, 1987-April, 1987

Review Course in Neurological Surgery
February 6-15, 1987
Specialty Review in General Surgery, Part II
February 16-27, 1987
The Biologic Basis of Neurology and Psychiatry
February 23-27, 1987
The Clinical Basis of Psychiatry
March 2-6, 1987
Current Problems in Pediatrics
March 16-20, 1987
Advances in Family Medicine, 1987
March 23-27, 1987
Specialty Review in Urology
March 23-28, 1987
Fiberoptic Colonoscopy
March 25-27, 1987
Fiberoptic Esophagogastric Endoscopy
March 30-31, 1987
High-Risk Obstetrics
April 2-4, 1987
Advances in Emergency Medicine, 1987
April 20-22, 1987
Specialty Review in Obstetrics and Gynecology
April 20-25, 1987
Modern Trauma Management
April 23-25, 1987
Advances in Surgery, 1987
April 27-May 1, 1987
Specialty Review in Radiology
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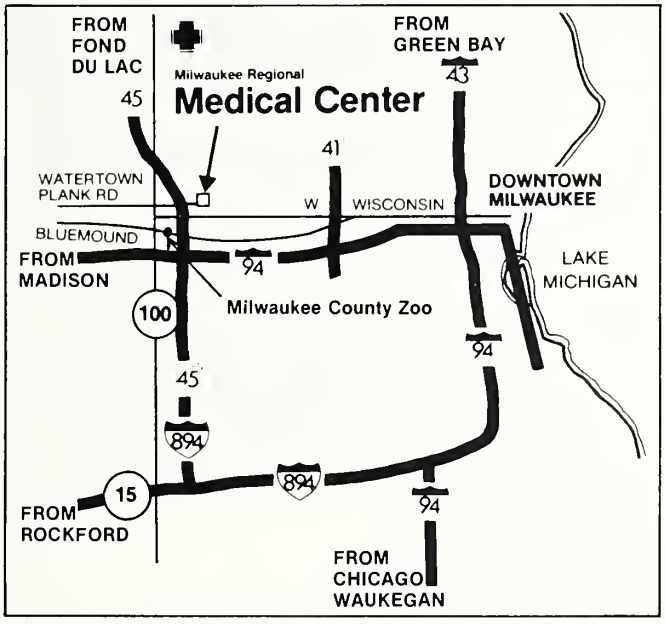
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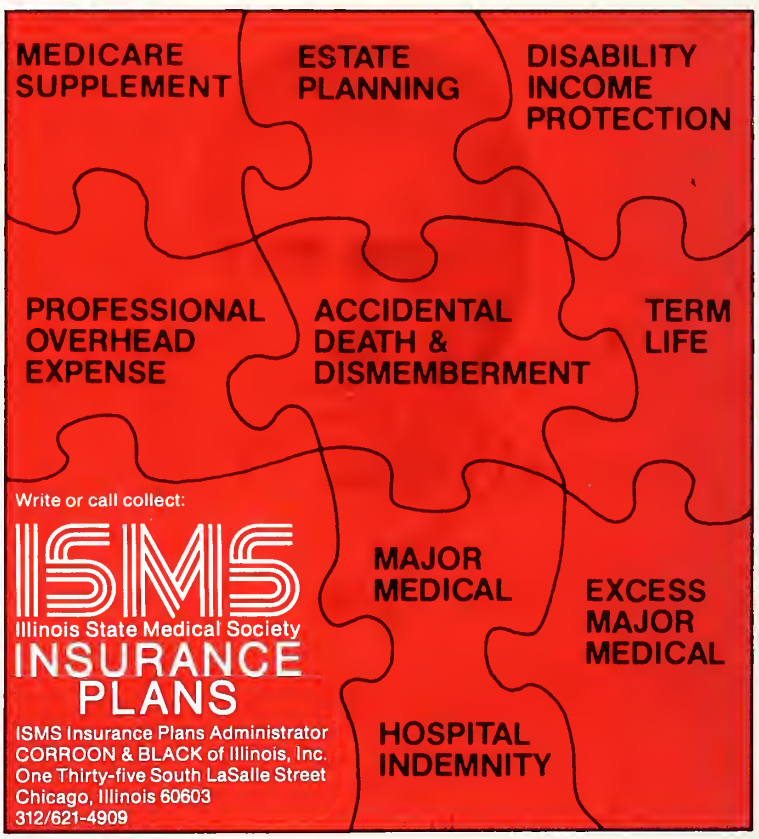
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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MOUNT CARMEL:
Orthopedic Surgeon, Pediatrician and Family Practitioner—Population 10,000. 64 bed JCAH accredited general hospital, HCA managed, newly built in 1983 replacing a well-established older hospital. Good secondary and high-school and junior college. First year guarantee and other excellent fringe benefits, a lovely river city with several large thriving industries. Any cultural or recreational benefits not provided here are available in nearby large city. Contact: William S. Vokonas, Administrator; Wabash General Hospital, 1418 College Drive, Mt. Carmel, 62863, or phone (618) 262-8621, extension 300. (1)

PEKIN:
Opened new 20-office multi-specialty physician's medical center attached to Pekin Memorial Hospital, a 202-bed progressive community hospital. Competitive income guarantee and relocation allowance available. Contact: Ruth Campbell, Court and 14th Streets, Pekin, 61554. (1)

PITTSFIELD:
Illini Community Hospital. Practice opportunities for FP, OB/GYN, Internist and Pediatrician; solo or partnership. Office space and financial assistance available. Service area 25,000. Excellent outdoor recreation. Close to St. Louis and Springfield. Good school systems, including colleges and universities. Contact: Kathleen Wegener, 640 W. Washington, Pittsfield, 62363. (217) 285-2113. (2)

SYCAMORE:
Internist with subspecialty interest in rheumatology to join a well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, 60178. (1)

The Role of the Medical Assistant

Medicine in the Marketplace

By Paula Burnett/Continuing Education Committee

Medical care has moved to the marketplace. Advertisements in newspapers and magazines depict new dimensions in health care. The number of physician practices adding business managers and marketing specialists to their payrolls is growing. The medical assistant can be a valuable aid in making your practice stand out. The key to success is education.

A medical assistant who is well-educated in current technology can give your practice that extra edge in the marketplace. Your assistant might become an expert on various health issues. For example, he or she might choose immunology, keeping your office up to date on new vaccines, time schedules for immunizations and fact sheets describing possible side effects. Another option might be to investigate what PPOs, HMOs, DRGs and Medicare assignment could mean to physicians, staff and financial statements. Your medical assistant may even have a flair for marketing and communications, and prepare a newsletter or handout for patient education. The options are limitless.

Physicians realize that education is critical to growth. Just as the physician must stay abreast of new medical findings, the staff should be encouraged to stay abreast of developments in the field. Ideas, goals, and learning can be rewarded in substantial ways. Other incentives for learning might include payment of seminar fees, professional organization dues, or a portion of college tuition.

Education provides competence for the present and preparation for the future. Your medical assistant should be challenged and encouraged to stay abreast of medical issues, to read, to inquire and to share newly-gained knowledge. Education will not only enrich your medical assistant, but ultimately your practice and your patient satisfaction.

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 E. Jackson St., Bloomington, 61701; Robin Bluestein, CMA-C, co-chairman, public relations committee, 2247 W. Estes Ave., Chicago, 60645; or Catherine M. Hill, CMA, co-chairman, public relations committee, 900 S. Plum Grove Rd., Palatine, 60067. ◀

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